Medical Benefit in Germany and Denmark

I. G. Gibbon

LIBRARY
UNIVERSITY OF
CALIFORNIA
SAN DIEGO

MEDICAL BENEFIT IN GERMANY AND DENMARK

Digitized by the Internet Archive
in 2007 with funding from
Microsoft Corporation

http://www.archive.org/details/medicalbenefitst00gibbiala

MEDICAL BENEFIT

A STUDY OF THE EXPERIENCE OF GERMANY AND DENMARK

BY

I. G. GIBBON, B.A., D.Sc.

AUTHOR OF "UNEMPLOYMENT INSURANCE"

NEW YORK: E. P. DUTTON & CO. | LONDON: P. S. KING & SON

1913

PREFACE

GERMANY has had a comprehensive scheme of compulsory insurance against sickness since 1884: Denmark has had a comprehensive scheme of voluntary insurance against sickness since 1893. In both countries sufficient time has elapsed for definite results to crystallise, and careful study should yield some interesting conclusions. In the present volume I have endeavoured to set out the principal facts respecting medical benefit under the insurance laws of the two countries, and to extract the lessons of their experience.

I have chosen Germany and Denmark as the field of study because in no other countries has insurance against sickness been so widely extended, and because they afford a contrast—insurance in the one being compulsory, in the other voluntary. It is surprising that this antithesis has not been more fully realised. It offers an opportunity for research which is seldom obtained.

I had originally hoped to have dealt with insurance in Germany and Denmark in all its aspects, in one or more volumes published at the same time. But as

I proceeded with the work the bulk of matter grew large, and as the part dealing with medical benefit was the most advanced, it was urged upon me that there would be great gain in publishing that separately. Something is lost by dealing with medical benefit apart from other related problems of insurance. But this loss is probably more than counterbalanced by the advantage of early publication.

As in my previous volume dealing with Unemployment Insurance, the present venture is strictly a scientific enquiry. The excellence of practical measures rests on the recognition, not only of the scientific rights and wrongs of the problem treated, but also on the limitations imposed by prevailing notions and conditions. I have had too much experience of practical administration not to realise the force of the latter. But the former is equally imperative. Just as in industry, so also in the world of social affairs, rule of thumb is giving way to scientific application based on methodical knowledge and solid research.

Under the head of medical benefit, I have dealt with questions relating to medical service, the provision of medicines and of other medical and surgical requirements, and institutional treatment. All these matters relate to curative treatment. In addition, there is the important question of preventive treatment. Much has been done in this latter direction both in Germany and Denmark, in regard to tuberculosis especially. The subject is a large one,

requiring careful study, and I have considered it better not to deal with it in this volume, the more so that in Germany most of the preventive work has been done, not by the sickness insurance societies, but by the invalidity insurance authorities.

In the case of each subject with which I have dealt separately in the present volume, I have stated first the legal provisions relating to the subject, and what has been the actual experience, in Germany and Denmark. I have followed this up with a chapter of conclusions, the reader thus coming on to the conclusions with the facts of experience fresh in his mind. Each conclusion is set out in the form of a proposition, the method adopted in my book on Unemployment Insurance.

The German insurance law has recently been in the melting-pot, and a new law was passed in 1911. References are made in the text to provisions of the new law: it has as yet only partly come into force. The experience which is considered in this volume is, of course, that under the old law.

In order to avoid cumbering the text with much detail, I have relegated most of the statistics to notes at the close of chapters. There are several appendices. Especially instructive should be the appendices giving particulars of the struggle between doctors and insurance societies at Leipsic and Cologne, and the appendix giving a translation of the detailed regulations of the Leipsic society as to the remuneration and control of doctors. Other appendices contain information as to the medical arrangements made in

some towns, and as to the organisation and position of the German doctors.

The conclusions are summarised in the last chapter. The gist of the conclusions may be briefly stated as follows :—

It is well that medical benefit should be provided by insurance societies in kind and without the interposition of an intermediate body.

Agreements as regards medical service are best made between the societies, or a federation of societies, and the doctors as an organised corporate body. The doctors, in such a system, undertake medical service as a corporate body. More efficient service is likely thus to be obtained, and the control of medical service is made easier.

Insured persons should not be restricted to some one doctor but should be allowed to choose the doctor by whom they will be treated.

Payment for medical service should be made in the form of capitation payments by the societies to the organised association of doctors, to be distributed by the association among the several doctors according to services rendered. Rates of medical remuneration from the working classes generally will rise.

Control of medical service should be exercised chiefly through the organisation of the doctors. The societies should restrict themselves mainly to broad questions of policy and results, leaving most of the details to the medical organisation. It is desirable that societies should be assisted in

their work by competent confidential medical advisers.

The provision of institutional treatment is essential for adequate medical benefit. But treatment of this kind is very liable to abuse and should be kept within narrow limits. Its provision to any considerable extent is not practicable to the lower ranks of workmen without a large measure of assistance.

The provision of medical benefit is attended with grave dangers, especially of valetudinarianism—the exaggeration of existing ills or the imagining of ills that do not exist. Germany has not escaped this danger, which has probably materially affected the success of her insurance schemes. Circumspect measures have to be taken if national health is not to be cankered by this peril.

While the provision of all benefit on an insurance basis is the ideal, there would be great advantage in making each insured person pay out of his own pocket for a small part of the cost of medical service and medical and surgical requirements. Abuses are checked by such a system. It affords a powerful lever for economy. It materially restrains tendencies towards malingering, and more important still, towards valetudinarianism.

Systematic measures should be adopted for educating the insured public in matters touching health and medical treatment. Thus alone can some serious dangers be avoided and the full benefit of insurance be received.

The foregoing is a brief summary of some of the principal conclusions. They are set out at more length in the last chapter of the book. In that chapter all the conclusions reached in preceding chapters are brought together, and endeavour is made to discover whether there are any organic principles underlying the whole. It is shown that there are such principles. Thus, just as workmen find that individual provision against sickness is not adequate, and that corporate provision, through insurance, must be made, so likewise are doctors finding that individual provision in arranging terms and conditions of medical service is no longer sufficient, and that in this sphere also corporate provision must be made. On the one hand, workmen organised in their societies; on the other, doctors organised in their associations; thus massed they can treat with each other on equal terms and in the long run secure, though doubtless not without occasional friction, not only more equitable conditions but also more efficient service.

The problems which cluster round medical service are part of the general problems of modern conditions, and are closely connected with the prevailing tendency which runs in the direction of incorporating individual action in that of the organised group. In dealing with questions of medical service, we are treating of a particular phase of some of the most fundamental problems of social organisation. And, dealing with them in relation to doctors, a class so different in circumstances and character from the

ordinary workman, it has been possible to reach some very suggestive conclusions.

I wish to express my deep obligations to the many persons from whom I have received assistance in my researches, and especially to mention—in Germany, Dr. Zacher, one of the foremost authorities on German insurance, who kindly read an early draft of the book, and Herr Hansen, the principal official of the invalidity insurance authority for Schleswig-Holstein; in Denmark, Miss Clara Black and Dr. Wittrup, the government inspector of sickness insurance, who read parts of the book dealing with their country. I am indebted to Dr. C. J. Thomas and to Mr. S. Stagg for reading the proofs and for many suggestions. And I am especially under obligation to Mrs. E. V. Kanthack de Voss, from whom I have received most generous aid.

I. G. G.

September, 1912.

CONTENTS

CHAPTER		PAGE
I.	INTRODUCTORY—GERMANY	1
II.	INTRODUCTORY—DENMARK	10
III.	INTRODUCTORY—MEDICAL BENEFIT	15
IV.	CHOICE OF MEDICAL PRACTITIONER—GERMANY	27
V.	CHOICE OF MEDICAL PRACTITIONER—DENMARK	40
VI.	CHOICE OF MEDICAL PRACTITIONER—CONCLUSIONS	43
VII.	REMUNERATION OF MEDICAL PRACTITIONERS—GERMANY	53
VIII.	REMUNERATION OF MEDICAL PRACTITIONERS—DENMARK	72
IX.	REMUNERATION OF MEDICAL PRACTITIONERS—CONCLUSIONS	81
X.	CONTROL OF MEDICAL SERVICE—GERMANY	107
XI.	CONTROL OF MEDICAL SERVICE—DENMARK	121
XII.	CONTROL OF MEDICAL SERVICE—CONCLUSIONS	125
XIII.	MEDICAL AND SURGICAL REQUIREMENTS—GERMANY	132
XIV.	MEDICAL AND SURGICAL REQUIREMENTS—DENMARK	148
XV.	MEDICAL AND SURGICAL REQUIREMENTS—CONCLUSIONS	154

CHAPTER PAGE

XVI. INSTITUTIONAL BENEFIT—GERMANY . . . 162

XVII. INSTITUTIONAL BENEFIT—DENMARK . . . 181

XVIII. INSTITUTIONAL BENEFIT—CONCLUSIONS . . 192

XIX. INSURANCE AND PUBLIC HEALTH AUTHORITIES . 204

XX. GENERAL CONCLUSIONS 211

APPENDICES

I. MEDICAL PRACTITIONERS IN GERMANY—ORGANISATION 227

II. MEDICAL PRACTITIONERS IN GERMANY—NUMBERS, ETC., 1885–1910 231

III. CONFLICT BETWEEN SICKNESS INSURANCE SOCIETIES AND MEDICAL PRACTITIONERS—LEIPSIC . . 236

IV. CONFLICT BETWEEN SICKNESS INSURANCE SOCIETIES AND MEDICAL PRACTITIONERS—COLOGNE . . 240

V. AGREEMENTS BETWEEN SICKNESS INSURANCE SOCIETIES AND MEDICAL PRACTITIONERS—LEIPSIC . . 247

VI. AGREEMENTS BETWEEN SICKNESS INSURANCE SOCIETIES AND MEDICAL PRACTITIONERS—MUNICH . . 268

VII. AGREEMENTS BETWEEN SICKNESS INSURANCE SOCIETIES AND MEDICAL PRACTITIONERS—FRANKFORT-ON-MAIN 271

PAGE

VIII. AGREEMENTS BETWEEN SICKNESS INSURANCE SOCIETIES AND MEDICAL PRACTITIONERS—STUTTGART . 275

IX. PARTICULARS RESPECTING TWENTY-EIGHT GERMAN DISTRICT SICKNESS INSURANCE SOCIETIES . . 277

X. PARTICULARS RESPECTING SICKNESS INSURANCE SOCIETIES AFFILIATED TO THE COPENHAGEN FEDERATION 279

XI. AGREEMENT BETWEEN THE FEDERATED SOCIETIES, AND THE MEDICAL ASSOCIATION, OF COPENHAGEN . 285

INDEX 291

MEDICAL BENEFIT

CHAPTER I

INTRODUCTORY

BEFORE proceeding to deal with the many questions which arise in connection with medical benefit, it will be well briefly to sketch in the first two chapters the general conditions with regard to insurance in Germany and Denmark, so that those who are not already familiar with the main outlines of insurance in those two countries may be able to place medical benefit in its proper setting. I propose also to deal in a further introductory chapter with some of the general questions which arise with regard to medical benefit itself, leaving the succeeding chapters free for more detailed matters.

GERMANY

The Insured

Insurance is compulsory both against sickness and against invalidity and old age. Roughly, it may be said that insurance against invalidity and old age has been compulsory for all manual workers, and, if the income does not exceed £100 a year, for some other classes of workers, such as foremen and commercial employees. Compulsory insurance against sickness, under the old law, extended to very much the same groups, with two large exceptions—agricultural workers and domestic servants.[1] These classes

[1] Some particulars respecting the insurance scheme for domestic servants at Hamburg, where they have been compulsorily insured under a local law, are given in pp. 179–80.

are brought within the scope of the new law. Under that law also, the income limit below which compulsion in sickness insurance is enforced for certain classes has been raised from £100 to £125 a year—much to the perturbation of doctors.

The number of persons insured in 1909 was—

against sickness, over 13,000,000, being 21 per cent. of the total population ;

against invalidity and old age, over 15,000,000, being 24 per cent. of the total population.

In the case of sickness insurance this wide extension has only been gradually attained, as will be seen from the following figures, which show for a number of years the percentage of the total population insured against sickness. The first imperial compulsory insurance law came into force in 1884 :—

Year.	Per Cent.
1885	10
1890	14
1895	15
1900	18
1905	20
1910	22

Certain classes of workmen who are not compulsorily insured may insure themselves voluntarily under the laws. Employers are not required to pay any contributions themselves in respect of persons thus voluntarily insured ; but the latter, if granted an invalidity or old age pension, receive the imperial subsidy for which the law provides.

With some exceptions, only persons employed can be directly insured under the laws. The obligation to become insured follows automatically on employment, and, generally, a person has no claim to become even voluntarily insured unless he is in employment. It thus follows that the wife and children of workmen are not insured unless they are themselves employed. But in the case of sickness insurance the societies may, subject to certain conditions, extend the benefit so as to include treatment for dependent

wife and children, and many societies do so. Women who have been compulsorily insured against invalidity and old age and cease to be employed on marriage are encouraged to continue their insurance voluntarily. If they did not continue their insurance, under the old law they were entitled, subject to certain conditions, to have returned to them one-half of the contributions paid in respect of them.

Organisation

The organisation of the insurance is very different in the case of sickness, and of invalidity and old age.

Sickness :—The insurance is effected through local societies of insured persons. To what society in the locality a person belongs is determined primarily by his employment. There are several different kinds of societies. A list, with a description of each kind, is given at the close of the chapter. Persons not otherwise insured became members of the communal insurance fund, which was administered by the communal authority.

It is important to note that a person has no choice of society. His society is automatically determined for him according to the place at which he lives or works and the employment he follows. The only exception is that a person who is adequately insured in a registered society—similar to an English friendly society—is released from other insurance. But he buys this freedom of choice by bearing the whole cost of insurance himself : employers have not been required to make any contributions in respect of an employee insured in such a society.[1]

The average membership per society (excluding miners' societies) in 1910 was 572. But a very large number of the societies have quite a small number of members. The old law only required a minimum of one hundred members in

[1] Under the new law, the employer in such a case will have to make the usual payment to the insurance funds, but not to the credit of the particular employee or his society. In the past it has been alleged that in some cases workmen have found it easier to get employment because insured in a registered society, the employer being thus relieved of contributions.

the case of district societies, and of fifty in the case of establishment societies. The new law makes for larger societies, and will cause the suppression of very many small societies.

Each society is financially independent. It receives into its own exchequer the contributions in respect of its members, and has itself to meet all the liabilities. This general statement is subject to qualification in the case of—

establishment and contractors' societies: the employer is liable to make good deficits;

guild societies: these societies are really part of the general activity of the respective guilds, and the guild funds are liable for deficits;

communal funds: the communal authority is liable to make good deficits.

Under certain conditions advances to cover deficits may be recovered.

Invalidity and Old Age:—The empire is divided into thirty-one districts, for each of which there is an insurance authority. Each authority manages the insurance for all the insured persons within its district.

With certain exceptions. For in addition to the thirty-one district authorities there are ten special trade authorities, for groups of railway-men, miners, and sailors: these groups therefore do not come under the district authorities.

Each authority is a unit for administration and partly for finance. As regards the latter, a large proportion of the financial liability is pooled for the empire as a whole, certain portions of the contributions of insured persons being credited to a central fund and certain of the liabilities debited to it.

Contributions

In the case of compulsory sickness insurance, the workman pays two-thirds of the total contribution, the employer one-third. The contributions are a percentage of the wages and may vary within certain limits.

For compulsory invalidity and old age insurance, the work-

man and his employer contribute in equal shares. In this case also the contributions are proportionate to wages.

Public Subsidy

The public authorities ostensibly do not grant any subsidy towards sickness insurance. Actually, a large amount of assistance is given. The insurance is supervised by the local authorities. The cost of supervision is considerable; it is borne by the authorities. Communal authorities had to make good deficits in the communal funds; thus the Hamburg authorities paid over £500 in 1909, and have had to make similar payments for many years. Nominally, payments of this kind could be recovered from the communal insurance fund. But often this was not likely to be practicable.[1] Moreover, the cost of the administration of communal funds was borne by the local authority.

More important still, a large amount of treatment is given to insured persons in public hospitals, and the charge for treatment is generally much below cost. This matter is fully considered in chapter XVI.

In invalidity and old age insurance, the imperial government contributes 50s. a year towards each pension, irrespective of its amount. In addition, certain expenses of management and supervision are borne by the public authorities, and some treatment to insured persons is given at the cost of the invalidity insurance authorities in public institutions at charges which are below cost.

Administration

Sickness Insurance:—The societies are self-governing. The managing bodies are directly elected by the insured persons and by the contributing employers, the number of representatives chosen by each group being proportionate to the contributions—that is, two-thirds by the insured, one-third by the employers. The new law deviates from this principle of representation in proportion to contribution in that it gives the employers special powers in some matters.

The societies are under the supervision of local authorities.

[1] The total amount expended in assistance of this kind is not large.

In communal insurance the insured had no direct voice in management, the insurance being administered as part of the ordinary business of the commune. Communal insurance is to be superseded under the new law, and a new kind of societies (*Landkasse*) is to be formed.

Invalidity and Old Age Insurance:—While the administration of sickness insurance is strongly democratic, that of invalidity and old age insurance is decidedly bureaucratic. The insured and employers participate in committees of management but their representatives are indirectly appointed, and, while the insured are by no means excluded from taking a part in the management, the actual administration is mainly in the hands of officials.

Benefits

Sickness Insurance:—The societies are required by law to provide—(i) medical treatment; (ii) drugs, and spectacles, trusses and similar requirements; (iii) money benefit; (iv) confinement benefit[1]; (v) death benefit. Instead of (i), (ii), and (iii), a society may provide institutional benefit, with, if the member has dependants, reduced money benefit. Communal insurance funds were not required to provide confinement and death benefits. Benefits are only directly provided for persons actually insured, except that a society may, by special regulations, extend certain benefits to dependants of members. The confinement benefit which societies are required to provide is therefore only for women insured because they are themselves employed.

The benefit has now to be provided for a minimum period of 26 weeks in case of need. Up to 1904 the minimum period was 13 weeks.

It is important to note that persons suffering from accident are entitled to receive benefit from the sickness societies for the first 13 weeks of disability.

Invalidity and Old Age Insurance.—The benefits have been—

1. An invalidity pension, in case of inability to earn one-third of what is normally earned by a healthy person of

[1] The new law provides for much more liberal maternity benefit.

the same station. The pension is given in the case of permanent disability, and also of temporary disability after 26 weeks of benefit from the sickness insurance.

2. An old age pension. This is given when the insured person attains 70 years of age. A person may not at the same time receive an invalidity and an old age pension.
3. Return of contributions (under the old law) subject to certain conditions, to—(*a*) a woman when she married; (*b*) the widow (or widower in certain cases) or children of a deceased insured person; (*c*) an insured person himself when he was compensated under the accident insurance for permanent disability. The amount returned was equivalent to what had been paid, or supposed to have been paid, by the insured person himself—that is, one-half of the total amount paid in respect of him. In case (*c*) contributions might be returned in respect of a person to whom a pension had been granted.
4. At the discretion of the insurance authorities, treatment for an ailment which threatens premature invalidity. A large amount of sanatorium treatment for tuberculosis is given under this head.

The new law provides also for the payment of pensions, under certain conditions, to the widow and children under 15 years of age of a deceased insured person. The rates of contributions have been raised in view of this additional benefit. Contributions will not be refunded under the new law as under the old. The other benefits remain.

A.—The Different Kinds of Sickness Insurance Societies.

Under the old law, insurance against sickness could be effected in one of the following forms. It must be remembered that a person has himself no choice as to the form his insurance shall take except that, if voluntarily insured to an adequate extent in a registered society, he is released from other insurance.

District Societies.

Are local societies, composed of workmen of the same trade or occupation (sometimes designated "local societies"). A society may take in several trades or occupations. At some places (*e.g.*, Leipsic) there is one "general" society for all persons.

Societies were constituted by local authorities on own initiative or on petition of workmen.

Comprised over 50 per cent. of persons insured in 1910.

Establishment Societies.

Society could be set up by employer if he employed not less than 50 insurable workmen. Authorities could also require employer to set up a society, even if smaller number of insurable employees: this power useful when employment has special risks.

If establishment society formed, all persons employed in the establishment for whom insurance compulsory bound to join, unless members of a registered society.

Comprised over 25 per cent. of persons insured in 1910.

Contractors' Societies.

These were a particular kind of establishment societies, which could be required of contractors of building or excavation works and the like. The reason for the formation of this special class was that persons employed on such work are subject to exceptional risks of sickness. The societies were temporary, lasting only so long as the job.

These societies are sometimes called building trade societies. But they extended to many other kinds of work besides building.

They included but a small number of members and cease to exist as a special class under the new law.

Guild Societies.

The guilds are allowed to administer their own insurance. Persons so insured are released from insurance in other societies. All persons employed by the members of the guild in connection with their craft become insured in the guild society, unless they are members of registered societies.

Communal Insurance.

Persons for whom insurance was compulsory not otherwise insured had to join the communal insurance fund of their locality. This fund was administered by the communal authority as part of its ordinary activities. The local authority could arrange that all persons compulsorily insured should join some one or other of the district societies, unless otherwise insured, in which case there was no need for a communal insurance fund.

Miners' Societies.

These societies are of ancient date. Miners are compulsorily insured in them. The societies provide, not only for insurance against sickness, but also against invalidity and old age, and for widow and orphan benefit. They are quite distinct from the other kinds of societies.

In addition to the foregoing, adequate insurance in one of the following kinds of societies complied with the requirements of the law.

Voluntary Registered Aid Societies.

These are similar to the English friendly societies. They have to comply with certain legal requirements, and are subject to certain supervision, but are largely independent. A person could elect to join one of these societies instead of one of those specially provided by the

law for compulsory insurance. But in that case he could not claim contribution from his employer towards his insurance.

The Government do not look with favour on the free societies. They are steadily on the wane and are further restricted in the new law. But they still comprise a large number of members.

State Registered Aid Societies.

Similar to the free registered societies, but are regulated by state laws. They have but a small number of members.

The conditions under the new law[1] as to the way in which insurance may be effected are very similar to those in the old law, except that—

1. District societies are not to be for particular trades or occupations, but are to be "general." There are reservations for existing societies.
2. Communal insurance funds will cease to exist.
3. A new class of society (*Landkasse*) will be formed. Agricultural labourers and domestic servants will generally be insured in societies of this kind. The societies will be administered on the lines of district societies, except that the administrators will be chosen (from contributing employers and insured workmen) by the local authorities, not directly by the insured themselves.
4. District and establishment societies must have a larger minimum membership—the former 250, the latter 100 (150 in the case of new societies), as a rule.
5. Contractors' societies will cease to exist as a separate class.

B.—THE FOLLOWING TABLE SHOWS THE PERCENTAGE OF THE TOTAL NUMBER OF INSURED PERSONS IN THE DIFFERENT GROUPS, EXCLUDING THE MINERS' SOCIETIES, AT THE END OF 1910:—

	Per cent.
District societies	52·3
Establishment societies	25·6
Contractors' societies	0·1
Guild societies	2·3
Communal insurance	12·2
Registered voluntary aid societies	7·2
State Registered aid societies	0·3

The total number insured, excluding miners, was 12,846,837. The miners' societies had about 900,000 members.

---

[1] The general provisions of the new law will be found fully set out in W. H. Dawson's "Social Insurance in Germany, 1883–1911."

CHAPTER II

Introductory

DENMARK

In Denmark, the State only participates in insurance against sickness. There is no assisted insurance against invalidity, though the subject has been under consideration for many years. But there is a system of old age pensions, to which the recipients do not directly contribute; the pensions may be given at as early an age as 60 years, under certain conditions.

The Insured

The sickness insurance is wholly voluntary.[1] There is no legal obligation on any group of workers to become insured. But the State encourages voluntary insurance by granting liberal subsidy.

Beneficiary membership in recognised societies—the societies which receive subsidy—is restricted, in the case of persons other than wage-earners, to those who are not in receipt of more than certain rates of income or in possession of more than a certain amount of property.

The number insured at the end of 1909 was 626,000, being about 23 per cent. of the total population and over 35 per cent. of the population above 15 years of age, having grown to this number from 117,000 in 1893 and 302,000 in 1900.

The fact is noteworthy that a larger proportion of the population has been directly insured against sickness in Denmark, with her voluntary system, than in Germany, under her compulsory scheme.[2] But, in comparing the two,

[1] See note at close of chapter as to alien seasonal workers.

[2] The new German law adds very largely to the number compulsorily insured.

it is important to take into account that in Germany the benefit often extends, beyond those directly insured, to their dependants. In Denmark, if the wife is to receive benefit she must herself be insured. More than half the persons insured are women. On the other hand, in Denmark insurance of the parent automatically carries, as part of benefit, medical (including hospital) treatment to dependent children under 15 years of age living with the parent.

Organisation and Administration

The insurance is effected through self-governing societies of the insured persons. They manage their own affairs, with very little interference from the governmental authorities.[1]

Each member is free to choose his own society. In Copenhagen and the district round there is ample choice, for there were no less than 75 recognised societies there in 1909. In the rural districts, however, there is practically no choice, for the Government refuses to recognise more than one society in a rural commune, in order to avoid the multiplication of very small societies and to prevent wild competition.

The societies are practically all limited to particular localities. As a rule, they are not restricted to particular trades.

Each society is a financial unit, bearing its own liabilities. Some amount of re-insurance is effected by a number of societies in respect of cases of consumption and lunacy.

Most of the societies are small in membership, the average membership in 1909 being 420. Nearly 500 societies had not more than 200 members each, and over 1,200 in all, out of a total of about 1,500, had not more than 500 members.

Contributions

Contributions are made by the insured persons only. Employers are not required to contribute—a radical difference from the German scheme. As a corollary, employers

[1] There is a special inspector of sickness insurance, who acts under the Minister of the Interior.

have no voice in administration, which is wholly in the hands of the insured, subject to the lenient supervision of the State.

Public Subsidy

A liberal amount of subsidy is given—

(*a*) The State contributes (i) 2 kroner (about 2s. 2¾d.) per member per year;[1] (ii) in addition, an amount equal to one-fifth of the contributions of the insured. These contributions of the State come to about 30 per cent. of the total income of the sickness insurance societies.

(*b*) Local and central authorities are required to give hospital treatment in respect of insured persons at a charge of not more than one-half that usually made to persons of the same class. Some authorities allow treatment at less than half the usual charges. Even the usual charges to workmen who are not insured are generally much below cost.[2]

(*c*) In rural districts, the local authority may be required, in case of need, to pay for the cost of the transport of a patient to and from a doctor or hospital, or of a doctor to and from a patient, up to a distance of 12 kilometres (about 7½ miles).

(*d*) A few rural local authorities give money subventions to societies in their districts. But these subventions are in some cases simply commutations of any claims under (*c*) above.

(*e*) Insured persons are also allowed privileges in regard to public relief. If such a one has exhausted his benefit and is still in need because of illness, he may be allowed public relief according to his necessities without its entailing any disabilities, provided that the total amount received does not exceed the benefit granted by his society. Assistance under this head is of course not often needed.

[1] The amount is reduced in the case of insured women or youths not entitled to a money benefit of at least 40 öre (about 5¼d.) a day.

[2] When the ordinary charges are markedly below cost, the rate to be charged to a society may be fixed by the Minister of the Interior.

Benefit

Societies are required to provide certain benefits :—

(*a*) *Medical Treatment.*

This must be provided in kind, unless special permission is given to the contrary. Hospital treatment must be provided where necessary and available. An important requirement of the law is that the insurance of a parent must carry, as one of the benefits, medical treatment to all dependent children under 15 years of age living with the parent. The question of the medical treatment of school children is thus largely solved.

(*b*) *Money Benefit.*

This must be provided for every male member above 18 years of age, and must not be less than 40 öre (5¼d. approximately) a day, or more than two-thirds of the recipient's usual earnings. It is at the discretion of a society whether money benefit shall be granted to women or to youths of not more than 18 years of age.[1]

The law does not demand that the societies shall provide drugs and other medical and surgical requirements as a condition of being recognised. Many societies, however, give these as part of benefit, while others pay part of the cost.

The societies are not allowed to provide death benefit under their general rules. But insurance for burial is common in Denmark, and is provided through clubs, most of which, though financially independent of, are connected with, and are under the same management as, sickness societies. A large number of the clubs are affiliated to a central re-insurance fund, which has been established with excellent results. A small subsidy is paid by the State to this fund. The burial clubs are supervised by the State.

Confinement benefit also is not required by law, and it is not usual for societies to provide it. It is the general practice, however, to give as part of medical benefit

[1] Money benefit must be provided for at least 13 weeks in a year. The claim of a member to medical benefit lapses, unless otherwise provided in the society's regulations, if he has received 60 weeks' benefit in the course of 3 consecutive years.

treatment required because of complications in childbirth.

A recent development of Danish insurance is the law of August, 1908, under which employers are required to insure against sickness alien seasonal workers employed by them for agricultural and other purposes. Some thousands of Poles and Russians come to Denmark just for the season. The number of such seasonal workers insured in the year ended February, 1910, was over 9,000. The contributions towards the insurance are paid wholly by the employers. A State subsidy of one krone per insured person is given. The insurance fund is administered by the State.

CHAPTER III

Introductory: Medical Benefit

There are some broad facts respecting medical benefit in Germany and Denmark with which it will be convenient to deal here, before embarking on more particular problems.

In both Germany and Denmark medical benefit is administered by the societies themselves; there are no intermediate bodies. Terms of service and matters relating to control are arranged directly between the societies and doctors. It is quite common for the negotiations to be carried out between a federation of societies and an association of doctors; but these act as the agents of the societies and of the doctors.

The supervisory authorities only intervene in disputes. In Germany, under certain conditions, the authorities may make terms with doctors which the societies within their jurisdiction can be required to observe. But this is only done in extreme cases when there would otherwise be failure on the part of a society to provide adequate medical treatment.

In Denmark the State has not expressly reserved to itself similar authority, and the intervention of the public authorities is less than in Germany. But the provision of medical benefit is one of the conditions of recognition, and the State has always the power of withdrawing recognition, with consequent loss of subsidy to the society, if satisfactory medical treatment is not provided for members.

In the second place, in both countries the societies are required normally to provide medical benefit in kind,

except that, in Denmark, societies need not, unless they choose, provide drugs and other similar requirements.[1] Societies are generally not allowed, that is, to restrict themselves to paying money benefit only, and to leave the members themselves to arrange for medical treatment. This is permitted only in exceptional circumstances. In Germany, under the new law, if a society is unable to make arrangements for medical treatment on reasonable terms, the supervisory authorities may allow it to pay additional money benefit, not exceeding two-thirds of the ordinary benefit, in place of providing medical service in kind. In Denmark, a few societies have been allowed to dispense with the provision of medical treatment, or to provide only part of the cost of treatment, on condition that they give equivalent benefits of another kind; but there also this is only allowed in special circumstances.

Conclusions

The foregoing particulars suggest the first two conclusions respecting medical benefit:—

1. *Medical service should be provided mainly in kind.*

If a person is ill the first need is to make him well. It is undoubtedly important that he should be provided with the means of maintenance for his family, but not so important as that he should be speedily restored to health so that he shall again take up his rôle of breadwinner.

But it may be contended that, if the society simply paid money benefit, there would be sufficient individual incentive to a sick member to secure efficient medical treatment. There are, however, a number of reasons which make it clear that it is better for the society to provide it—

(*a*) The society can better control the doctors in order to ensure good medical treatment.

(*b*) Adequate medical treatment must include some provision for institutional treatment (see chapter XVIII.).

[1] Until 1892 the registered (friendly) societies in Germany were allowed to give money in lieu of medical benefit (a fact which has to be taken into account in interpreting the figures of the expenditure of these societies), and it is alleged that they were in consequence much better able to compete with the other societies.

This can be much better arranged by a society than by individual members.

(*c*) Supervision is much easier if the society itself arranges for treatment. If each member is allowed to make his own arrangements, the society will have no guarantee, without laboured precautions, that a member is receiving proper treatment.

(*d*) Malingering is difficult to check; valetudinarianism still more so. A society can deal with these dangers more effectively if medical service is under its control. Better measures for detecting abuses can then be devised.

(*e*) Even if a society only gives money benefit, it must still rely largely on the doctors. Money benefit cannot be given, without inviting bankruptcy, except on definite evidence of inability to work. For this purpose, medical certificates are necessary.

And it is around the giving of such certificates that some of the thorniest problems with regard to the control of doctors arise. It is more likely that satisfactory conditions will prevail if doctors do not simply give certificates for the society, but render general medical service under agreement with the society.

(*f*) The society can probably arrange more economically for medical treatment.

The society will be better able to resist exorbitant demands. Further, if medical service is arranged through the societies in a district, especially if arranged through a federation of the societies, there is more likely to be reasonable accord between the number of doctors practising in the district and the demand for them.

And if most of the doctors are fairly well employed, efficient service is more likely, in the long run, to be obtained at reasonable rates than if there are many more doctors than need be. For experience shows that, in countries where insurance extends

widely, doctors will combine closely to maintain their interests, and combine effectively, because of their monopoly. Such being the case, if there are more doctors in a district than are really required, there is obvious danger that they will force rates of remuneration unduly high in order that all, or nearly all, may have a reasonable chance of a moderate livelihood. In fact, the German sickness societies contend that this is in Germany one of the principal reasons why the doctors press for higher rates of pay.

(*g*) There will be difficulties in providing benefit if, while the society does not itself provide medical benefit, it nevertheless is to provide money benefit roughly equivalent to the cost of medical treatment—in addition, that is, to money benefit for maintenance.

There need not be great difficulties of administration in this connection when the member is wholly disabled for work. But what of the cases where the member requires medical treatment while continuing at his employment—and these are the majority of cases? Unless the society itself arranges for treatment, there will be great risk of abuses in the payment of money benefit in these cases.

(*h*) Further, an insurance society, if far-sighted, will not content itself simply with the cure of existing ills. It will aim at preventing disease, at developing more hygienic habits and conditions, and at raising its members to a higher standard of health. But if a society has not a voice, or only a minor voice, in medical treatment, its opportunities and endeavours in this direction will be seriously hampered.

(*i*) Lastly, there is much more promise of advantage to the community generally when medical treatment is arranged through the society.

One of the needs of the present time is more co-operative organisation. As previously stated, proper balance between number of doctors required and

number available is much more likely to be secured when arrangements for service are made by the clients, organised in a society, or a federation of societies on the one hand, and the doctors organised in their association on the other. More satisfactory terms also can thus be arranged and more efficient service ensured. And such a system holds rich promise of firmer organisation of the medical profession, which, while certainly not without its dangers, should on the whole yield a large margin of gain. The trend of modern conditions is steadily in the direction of such an organisation of both bargaining parties, and it seems highly probable that such a culmination must result if modern tendencies continue to prevail.

The foregoing comments contemplate normal conditions. Exceptional circumstances may of course arise which justify exceptional arrangements. The managers of German sickness societies have in the past complained that they were largely at the mercy of the doctors because they were always compelled to give medical service in kind. The new law provides that under certain special conditions societies may give additional money benefit in place of medical service.

We have considered the antithesis of the provision of medical service (i) by the society, and (ii) by the member himself. But the two are not necessarily exclusive. They can be combined. And experience shows, in fact, that there is gain in combining them and in making the member pay part of the cost of medical service, a small part, out of his own resources. The subject is considered at length in chapter IX., page 92.

2. *There is advantage if the societies, or federations of societies, deal directly with doctors, or associations of doctors, in matters of medical benefit.*

This is done in Germany and in Denmark. There is no intervening authority.

There are many strong reasons in favour of this system.—

(*a*) It is likely to be more economical.

The interposition of an intermediate authority cannot but add to the cost. There will be duplication of work. Since the societies must depend on medical certificates for payment of money benefit, they are not likely to keep their hands free of medical control. There is risk therefore of friction—and of inefficiency, not simply because of friction but also because each body may rely on the other for exercising proper control and the work, being partly the business of both, may not be efficiently done by either.

An intermediate body composed of persons not directly responsible to those whose money they are spending may prove an expensive body, unless sage precautions are taken.

(*b*) An intermediate authority is not likely to be so efficient.

For very much the same reasons as it is not likely to be so economical. Moreover, concentration of interest is as essential to social, as to individual, efficiency. But by interposing an intermediate body interest is divided. Neither this body nor the society receives, or probably will realise, the full burden or force of sickness, and effort may in consequence be slackened.

(*c*) Friction between doctors and societies will not be removed by bringing in an intermediate body.

Societies will still have dealings with doctors, both through representatives on the intermediate body, and—fruitful source of friction—through requiring medical certificates of inability to work. There is much more hope of peace if the doctors and the societies stand squarely face to face with

their difficulties and are not divided by a screen which does not part but only hinders.

Further, the members of a society have to pay for medical benefit even if it is administered through an intermediate body, and they will probably force their society to interfere in matters dealing with medical treatment if they think they have serious grievances.

(*d*) Preventive work can be more effectively done when societies or their federations deal directly with medical benefit.

In this respect again, the virtues of concentration are great. When a society itself feels the full force of sickness, has itself to meet all the resultant liabilities, there is much more likelihood of strenuous endeavour towards effective preventive work. Moreover, the societies will be seriously crippled in such work if they are not directly in touch with disease and its treatment and with those whose special business it is to understand and to cure it.

Besides, as is being more and more recognised, preventive work depends largely on personal hygiene, on inculcating proper habits of thought and of conduct. In order that this may be effectively done, it is obviously desirable to work through an organisation which is in close touch with persons and engages their keen interest. The insurance society, with its democratic constitution, is just the kind of organisation which is needed. An organisation of this kind should be able to strive for personal hygiene with far more success than an organisation or authority in which the men do not themselves directly participate.

Distrust of the administration of medical benefit by the societies themselves is felt chiefly in two quarters—among the doctors and by those who believe strongly in the advantages of what is termed an unified medical service for

the whole needs of the community, or at least for the needs of those who cannot pay freely for medical treatment.

(i) *Doctors.*

(*a*) The experience of doctors with insurance societies has not been encouraging for them. They complain bitterly in Germany and in Denmark, as in other countries, that they have been underpaid. Why has this been so—assuming that the complaint is true, as it undoubtedly is in many cases? Is it not because doctors have competed against one another for insurance custom? Facing them has stood a solid society. Naturally, under such conditions, medical service has fallen to a low price.

It seems obvious that all that the doctors have to do is to organise closely in their turn, to present a solid professional front to those who would beat them down. The experience of Germany and Denmark shows conclusively that doctors can win their way by effective organisation. The remedy lies in their own hands.

(*b*) Doctors are likely to secure more independence of control by dealing directly with the societies.

The meddlesome interference of lay control is one of the principal grievances of doctors against insurance societies. The experience of Germany definitely shows, as will be described later, that if doctors are strongly organised and treat with the societies as a corporate whole, they can gather a large part of the control into their own hands.

Doctors are not likely to obtain nearly so much freedom from a body constituted solely for the administration of medical benefit—a body which, by the way, must contain a large proportion of society representatives if it is not to be wholly undemocratic. An authority constituted for the special purpose will almost surely seek to justify its existence by administering in detail.

It is manifest that the question is primarily one of organisation. If the doctors close their ranks in disciplined purpose, if they stand firmly shoulder to shoulder in common interest, they can make their own terms with the societies within reason—and sometimes beyond it—and gain fair remuneration and freedom from wasteful and vexatious control. Strongly organised, they have everything to gain from treating directly with the societies.

(ii) *Unified medical service.*

The course of argument in favour of unified service should by now be familiar. Treatment of disease is only one road towards health. There are other avenues of approach, some of them much more valuable. The invasion of disease can be barred by wise measures of public health and treatment, where need be. Especially is this so, it is contended, in the case of the young. By periodical examination of infants and of school children, backed by clinics where necessary, mistakes can be avoided and defects removed which would otherwise lead to future ailments and general lack of health and efficiency. And it is also urged that other branches of public medical service — poor law, factory, police — should be linked up with each other and with the rest. There are many advantages which are claimed for such unification; for instance—

That the problem of health and sickness could thus be treated as an organic whole. It could be attacked from all sides. Preventive measures could be pushed into all classes of the community and pushed effectively.

That this is the only way to secure an efficient service even in the matter of treatment. Otherwise, there is risk that treatment will only be of symptoms, not of fundamental causes.

That it would be economical to the community. It

is urged that a unified service would result in a remarkable general improvement in health.

That it would be a step forward in the general organisation of the community. A unified service means in practice a public service, in the minds of those who support it—though it need not necessarily be so—and the demand for it in many cases gains most of its force because it fits in with the socialistic dreams of its advocates.

Obviously the question is too large to be dealt with simply as a side issue in a volume dealing with medical benefit. I can here only give some indications why such a policy would probably not yield satisfactory results.

(*a*) There is danger that a unified public system would become unified to solidity. Service might conceivably be fairly efficient for a generation. But there is little doubt that it would tend to become stereotyped. It would become very immune to new ideas, and in medicine, as in other spheres, it is the new idea which counts most for progress.

(*b*) It is doubtful whether it would maintain a high standard of efficiency even for one generation. The service might become wrapped in formality, and throttled out of life. Stimulus to good work and to initiative would be reduced. Slackness would creep into many places because the practitioner was moved from the immediate control of his clients. A large proportion of the best men would be outside the service, attending persons who could afford to pay for private service.

(*c*) Valetudinarianism might become rampant—that habit of mind which exaggerates existing ills and creates others of its own imagination. No greater curse could fall upon a nation. And it would almost surely grow, with the fertility of weeds, under a system in which medical service would be obtained free of charge or at very small cost and where there was practically

no restraining influence of neighbours intolerant of abuses because their own pockets were obviously being picked.

Malingering would also probably be a grave evil, though less serious than valetudinarianism.

(*d*) The plea for a public service is based largely on what is essentially a primitive view of hygiene. It leans on the notion that the material environment is the most important matter. True, in these latter days, ideas of the importance of personal hygiene have been grafted on to these notions, but it is in material environment that the doctrine has its roots.

But modern research is all in the direction of showing that other factors are much the more important—personal hygiene, which depends on character and the subtle subconscious make-up of mind, and conditions of heredity. Character and the sub-conscious foundation of good habits are best acquired in active self-government, whether individual or as member of a society or group. Regulation of life so as to take wise advantage of conditions of heredity will only be secured in a democratic community when the people govern sufficiently closely to the core of things to realise consequences.

(*e*) Under a public medical service, the power of the doctor would be very great. Dealing with the intimate concerns of life, it might well become intolerable. "Medical priesthood" is not altogether an empty phrase. It does crystallise a tendency—a tendency already manifest. Human nature being what it is, no profession, medical or other, could be entrusted with wide compulsory powers without results fitter for the Peru of the Incas than the Europe of democracy.

(*f*) The notion that a unified state service would be economical is probably a delusion. There would almost surely be a large increase of work. Much

service would almost certainly be only mildly efficient, for reasons already given. The general standard of work, in quality as well as quantity, would probably be less in a public service, with its sheltered security, than under a more strenuous system.

(*g*) Lastly, against the ideal of a community in which functions are concentrated under governmental control may be set an ideal in which persons are organised in self-governing groups according to their functions, needs, and interests, and all these groups organised in turn into a co-operative whole for the common good. This form of organisation provides full and free outlet for the surging aspirations which make the present times so full of uneasy travail. It offers scope for the rich complexity of modern life, and promises a blend of order and freedom which cannot be obtained under any system of widely extended, finely netted, governmental administration.

CHAPTER IV

Choice of Medical Practitioner

GERMANY

The free choice of doctor is one of the bitterest causes of strife between doctors and sickness societies. Generally, the doctors are strongly for free choice and the administrators of societies as strongly against it. Employers are likewise stridently opposed to free choice.

Free choice has been conceded by many societies. But the largest number still narrowly restrict the freedom of their members in this matter. Nevertheless, the tendency seems to be steadily in the direction of free choice.

The foregoing are the broad facts of the situation. More detailed particulars are given in the following sections.

Forms of Choice

It is necessary to distinguish between different systems.

1. *Unrestricted free choice.*

   In practice, it is obvious that this cannot wholly be conceded. Considerations of distance must be taken into account, and a society must restrict its members to those doctors who are prepared to give treatment on the terms which the society is willing to grant.

2. *Organised free choice.*

   In this system the society makes an agreement for medical service with an association of doctors. Any member of the association is allowed to contract for the treatment of members on the terms agreed between the society and the association.

3. *Limited choice.*
   The society itself chooses a number of doctors for medical service and allows freedom of choice among these.

4. *No choice.*
   The society employs district medical officers. A member must go for treatment to the doctor for his district.

Each of the different kinds of systems has prevailed in Germany, with the exception of the first. However wide the choice, there is necessarily some restriction when attendance is required at the home of the patient; a doctor in the neighbourhood has generally to be chosen, unless a doctor at a distance is prepared to attend without increased cost. Members are allowed medical attendance at the cost of their society only when they employ the doctor or one of the doctors allowed by the society. But in cases of urgency, when the services of a society doctor cannot readily be obtained, the cost of the services of another doctor may be paid.

Legal Provisions

The existing law requires societies to provide medical benefit in kind. How it shall be provided is left, within certain limits, to each society for its own decision.

The societies complain that the obligation of providing medical benefit in kind places them in the hands of the doctors. They, the societies, must provide medical service. There is no corresponding obligation on the doctors to give their services. The latter are therefore, allege the societies, placed in a position to dictate terms.

Especially so does this seem to be the case because it is not left wholly and finally to the societies to determine what is adequate medical service. If a sufficient number of the members of a society complain to the supervisory authority that adequate service is not being provided, it is the duty of the authority to make inquiry into the matter,

If the authority considers that the service is not adequate, it can call on the society to make good the defect, and, failing compliance, can itself make agreement with doctors for medical service at the cost of the society, which agreement the society is bound to observe.

There are several instances in which agreements of this kind have been made by supervisory authorities over the heads of sickness societies. Information respecting the two most notable instances, those at Leipsic and Cologne, are given in appendices III. and IV.

The new law contains a number of important changes touching choice of doctor, to the advantage partly of the doctors, partly of the societies.—

1. Choice is to be given between at least two doctors, unless this is not practicable except at excessive cost to the society.
2. A member must be given choice between all the doctors on the list of his society provided that he undertakes himself to pay the additional expense, if any, of employing one doctor rather than another.

   While the doctors are not satisfied with these concessions, they think that they will be valuable aids in the struggle for free choice. The concessions will do much to break the monopoly of the district doctor—of the medical society "kingships," as they are called. And once a breach is made, the doctors think that it will be much easier to force down all the barriers which block the way to full organised free choice.
3. If a society is not able to arrange for medical service on what seem reasonable terms, it may, with the consent of the supervisory authority, pay an additional amount in money benefit, the addition not to exceed two-thirds of the ordinary money benefit, in place of providing medical benefit.

   This is a concession to the societies and places a weapon in their hands in conflicts with doctors. If an arrangement of the kind has been made, the supervisory authority may authorise the society to require sick mem-

bers to accept hospital treatment even when, in ordinary circumstances, they would have the right to refuse it.

The final voice as to medical service rests with the supervisory authority. Not only is its consent necessary to the exceptional arrangements described above, but it retains the power of making agreements for medical service against the will of the societies.

Attitude of the Medical Profession

Doctors, as stated, are generally for a full measure of organised free choice. Not all; many of the doctors now in possession who have a monopoly, whole or partial, of insurance practice in their district, would like to retain their preferential position. But the policy of the doctors' organisation is vehemently in the other direction. Free choice is one of the main planks of their platform. The demand for it is genuine and insistent, and has been enforced by strikes.

The organised doctors have striven to secure free choice by legal enactment. But they have not met with success. The opposition of societies and of employers has been too powerful.[1] The efforts of the doctors are now mainly pushed along lines of independent action.

The demand for free choice is defended on many grounds—

1. Efficiency of service.

   The patient should be treated by the doctor in whom he trusts, not by one nominated by the society.

2. Opposition to monopoly of service.

   Under monopoly, a few wax fat, the many wane. The younger practitioners especially are penalised. And efficiency of service is not secured. Multitudinous patients and hurried treatment go together.

3. Degradation of the profession.

   This follows from the monopoly of service, with low rates of payment and scamped work. Efficient treatment becomes impossible.

The organised doctors aim, not simply at free choice, but at organised free choice. This is well illustrated in the

[1] The doctors contend that the State, as a large employer of labour, is not impartial.

particulars of the strife at Leipsic and at Cologne. Among the reasons for their preference for this system are—

1. When agreements are made with a society by an association of doctors, the latter are in a much better position for bargaining.
2. Organised choice gives them much more security of tenure. A society may not be able to dismiss a doctor without the intervention of the doctors' association, and, if the doctor or association chooses, without the concurrence of the arbitration committee.
3. The doctors secure a large measure of self-control. Supervision over the doctors is exercised primarily by their own association. This matter is further considered in chapter X.

Attitude of the Societies

The administrators of sickness societies oppose free choice very stoutly. They assert—

1. That it renders effective control impossible.
2. That it makes for inefficiency of service.

   Members go to the complaisant doctor, not necessarily to the one who gives good treatment.
3. That it increases costs very much.

   The doctors, organised, are the more effective for demanding large remuneration. Further, patients patronise doctors who readily certify inability to work, and who prescribe medicines which are liked. The difficulty of control in other ways also adds to the cost of service.

Among individual members of societies there is naturally much partiality for free choice of doctor. The ordinary man does not wish to have his doctor nominated for him. The German sickness societies are supposed to be democratically managed. The insured members themselves have the major voice in their administration. It may, therefore, seem contradictory that the managers of societies should be so strongly opposed, and effectively opposed, to free choice. There are various reasons for this apparent contradiction.—

1. The doctors ascribe it largely to the "terrorism" of the social democrats.

   Large numbers of the societies are managed by persons who are social democrats. The managers of societies have various means of penalising a member who presses hard his opposition to their views. And they can retaliate more effectively because they are in close touch with the avowedly social democratic organisations.

   There are, no doubt, some grounds for the doctors' diagnosis, though probably it is much exaggerated.
2. A large proportion of the members take little active part in the management of their society.

   Thus in the Leipsic Society the largest percentage of members who have ever voted for the election of representatives for the general assembly of the society was under 22 per cent. All the candidates of the insured chosen at the election in 1908 were those put forward by the social democrats. It is easy to see that, in such circumstances, the affairs of a society may easily fall into the hands of an energetic group.
3. There is undoubtedly genuine distrust of free choice among many thoughtful members, much though they may like it in theory.

   They fear that it would so increase the difficulties of control and add so considerably to the expenses that the solvency of their societies would be endangered. And the same attitude is taken by many impartial experts outside the societies who are keenly alive to the difficulties of the problem.

A large number of societies have conceded organised free choice. Among the most notable is the Leipsic District Society. This society makes agreement with the two medical associations in its district for medical treatment. The two associations are official bodies, with certain administrative functions, and include all practising civil

doctors within their areas. Any doctor belonging to either of these associations may contract with the society for medical service on the agreed terms. The members of the society have freedom of choice among the doctors who have so contracted. The employment of a doctor by the society can only be terminated on substantial grounds, and, in case of dispute, the matter has to be determined by the arbitration committee, which contains an equal number of representatives of the society and of the doctors and, in addition, impartial persons. The society has agreements with some 400 doctors.

The main lines of the existing system were laid down after a bitter dispute between the society and the organised doctors, when the former tried, with scant success, a system of district doctors. An account of this dispute and a translation of the agreements made by the society with the medical associations and with doctors is contained in appendices III. and V.

At some other places, among them Munich and Frankfort-Main, agreement is made between a society and a special association formed to uphold the free choice of doctor. At Munich agreement is made only with the association. Contracts are not made with individual doctors.

Cologne is another place where there have been interesting developments with regard to the choice of doctor. In 1904, open conflict broke out between the societies and the doctors. The latter demanded, among other things, that the societies should allow organised free choice in place of the limited free choice which had previously prevailed, and refused service on terms offered by the societies. As the societies were not able to provide adequate medical service for their members, the supervisory authority made agreements with the organised doctors over the heads of the societies. The agreements provided for free choice. This continued until 1909, when the agreements ended. The societies had by that time been able to make their own terms with a sufficient number of doctors, many of whom had been specially imported, to satisfy the legal require-

ments, and the organised doctors were excluded from service. The societies now employ from 70 to 80 doctors, among whom they give free choice to their members, and they find it expedient to advertise prominently that they give this choice.

It is generally only at the point of the bayonet that the doctors have been able to secure any large measure of free choice. They have yet to convert the societies. The question was warmly debated at the general meeting in 1911 of the National Federation of District Sickness Societies—a very representative body. At the head of the section favourable to free choice was Herr Pollender, president of the district society of Leipsic. Firm standard-bearer of the opposite side was Herr Frässdorf, president of the district society of Dresden, which employs salaried district medical officers. Herr Pollender had told of the success which had attended the arrangements at Leipsic, where there is organised free choice. But the meeting, as was to be expected, was strongly against free choice.

The issue was probably clouded to some extent by the new bitterness which has arisen between doctors and sickness societies in consequence of the extension under the new law of compulsory insurance to persons with higher incomes than heretofore (see p. 65), but, even apart from this disturbing influence, the result of the meeting accurately reflected the prevailing views among those responsible for the management of sickness societies.

Attitude of Employers

The attitude of the employers is reflected in the establishment societies, which include over a quarter of the total number of persons insured, much the largest group after the district societies. The establishment societies are even more bitterly opposed to free choice than the district societies.

Employers are against free choice for much the same reasons as the administrators of societies. They deprecate the loss of control and fear that the expenses would be

very much increased. And this is a serious consideration to them, for, in certain circumstances, the employer is liable to make good the deficits in his establishment society.

The National Federation of Establishment Societies has taken a very active part in the resistance to the organised doctors. It has pushed its campaign into the enemy's territory and actively encouraged the efforts of a rival association of doctors—the *Reichsverband*—which is willing to leave the societies to determine for themselves what form of medical service they shall provide. But this association is not of much account.

There are a number of other minor questions, incidental to those already stated, which it will be well briefly to consider.

Qualifying Period of Residence

When free choice of doctor is provided, it is sometimes stipulated that a doctor shall not be eligible to treat insured patients unless he has resided in the district for a certain period. This period, in the case of the Munich society, is two years. At Frankfort it is six months.

Incidentally, of course, such a restriction has the effect of limiting free choice. The societies defend it on the ground that they should have an opportunity for getting to know their man before entrusting the treatment of patients to him.

The doctors oppose it, probably largely in the interest of the younger doctors, who obviously are the ones hardest hit. Clearly, if in a district most of the practice lies among insured persons and a doctor is not permitted to treat any of these, in ordinary circumstances, for the first two years of his settlement, this stipulation may be an effective bar to his settling in the district at all, and the monopoly of the doctor or doctors in possession may thus be perpetuated.

Unorthodox Practitioners

More serious is the employment of unorthodox, especially unqualified, practitioners of healing. The doctors wage hot crusade against the employment of the latter. They aim

at including in their agreements with sickness societies a stipulation that all treatment shall be by qualified practitioners, and this has been achieved in some cases.

Under the old law, it has been held that a society could, if it so chose, allow a member to receive treatment from an unqualified person if the patient so desired. The society could not compel a patient to accept such treatment, but had to provide service by a qualified practitioner if this were demanded. Even when service by an unqualified person was allowed, the society might stipulate that it would only accept certificates from qualified practitioners. The new law is more favourable to the medical profession, and service by unqualified persons can be given only within certain limits and with the consent of the principal administrative authority.[1]

Many societies have allowed treatment by unqualified practitioners, at the option of their members. Germany is the home of nature-healing, and this form of treatment is looked upon with the more favour by administrators of sickness societies because it reduces the very large expenditure on drugs which goes with ordinary treatment and is so serious a drain on the resources of societies. This was one of the principal reasons which induced the Federation of District Sickness Societies of Saxony to pass a resolution, brought forward by the Leipsic Society, at their meeting in 1910, to petition the Government to establish a chair of nature-treatment at the Leipsic University in order that researches might be made and instruction given in this form of treatment. The movement in favour of nature-healing is not necessarily in opposition to the qualified practitioners, for there are many among them who practise it, though those who adopt it as their sole method of treatment are apt to be regarded as charlatans by their more orthodox professional fellows.

Clinics

Medical treatment, other than that at a hospital, is usually given at the home of the patient or at the surgery of the

[1] It is not clear what exactly will be the effect of the new provisions.

treating doctor. Use is made of the private clinics of doctors. Endeavour has been made by some societies to establish clinics of their own for general treatment. At Leipsic, during the conflict between the society and the organised doctors in 1904–5, the former established three clinics, with salaried medical staff. The clinics were not very successful and were abandoned even before peace was definitely made with the organised doctors. The present agreement between the Leipsic District Society and the Medical Associations contains a stipulation that clinics shall not be established during the period of the agreement. The District Society of Chemnitz, in Saxony, likewise established a clinic at which several doctors were employed, and which contained provision for dental treatment, baths, etc. Members of the society were apparently bound to use the clinic, under certain conditions. But a new agreement has now been made between the society and the medical profession, in which free choice of doctor is conceded, and the clinic is now of little importance. In Prussia it appears that the authorities hold that societies have no authority to establish general clinics of this kind.

Some societies have established dental clinics. There is an interesting institution of the kind at Düsseldorf, established by one of the district societies. A special staff of officers is employed for the clinic. Members of the society receive ordinary dental treatment free of charge. Special requirements—gold-filling, for instance—are provided at extra payments fixed in the rules.

The Hamburg authorities have a dental clinic for members of the society for domestic servants administered by the authorities. It is stipulated in the rules that treatment shall only be provided for actual ailments, not for the sake of appearance or even to prevent possible ills. On the other hand, the invalidity insurance authorities will provide dental aid if satisfied that this is desirable for preventing premature invalidity.

Dental Surgeons and Dentists

Dental treatment is provided by independent dental surgeons or dentists. What has been said with regard

to choice of ordinary medical practitioners applies also largely to dental surgeons and dentists. The latter favour free choice, but the societies are generally reluctant to allow it. Unqualified practice is more prevalent in dentistry than in general medical practice.

The new law contemplates that dental treatment shall ordinarily be given by duly qualified persons. But treatment may be given by other persons with the consent of the patient, or, in case of necessity and with the consent of the principal administrative authority, even though the patient wishes otherwise. This provision is obviously of great advantage to the societies in case of conflict.

Dental surgeons and dentists are generally not so well organised as the ordinary medical practitioners. But some societies give free choice. The Munich district society enters into agreement with associations of dental surgeons and of dentists. Dental treatment is also provided by ordinary medical practitioners.

Invalidity

In invalidity insurance, the question of choice of doctor arises practically only in connection with the giving of certificates of invalidity. Treatment granted by invalidity insurance authorities is generally given at institutions, and the insured person, if he desires to receive the treatment, has to go to the institution designated by the authority.

With regard to certificates of invalidity, it is the practice of the insurance authorities to accept in the first instance a certificate from any qualified medical practitioner attending the claimant. But the claim is subjected to the examination of the insurance committee for the locality in which the claimant resides and of the insurance authority. Both these employ confidential medical advisers, and, if the case is not clear, the claimant may have to submit to examination by one of the advisers, or possibly, in difficult instances, by the confidential advisers of both groups.

The person employed by the local insurance committee as confidential medical adviser is generally required to devote only part of his time to his work, and in rural districts he is frequently the *Kreisarzt*, an officer who roughly corresponds to the medical officer of health in England.

CHAPTER V

Choice of Medical Practitioner

DENMARK

The law does not contain any provision relating expressly to choice of doctor. It is left entirely to the societies to make their own arrangements.

The attitude of doctors, societies, and insured persons towards the question is very much the same as in Germany. Doctors favour free choice. Where the system of employing one district medical officer has been in force for many years, there may be some difficulty and reluctance to pushing the demand for free choice. Societies oppose free choice. They think that it adds to expenses. Members would like to be able to choose their doctor. But there does not seem to be any strong demand from their side. Most of the societies are small. Administration is very democratic. The more thoughtful members probably appreciate the difficulties which arise when each insured person is allowed to choose his doctor.

Speaking generally, the country may be divided into three divisions with regard to choice of doctor.

(*a*) *Copenhagen and Frederiksberg.*[1]

In these towns, societies generally have proceeded on the plan of mapping out their areas into districts and appointing to each district a medical officer, to whom members living in the district have to go. But the tendency in recent years has been to relax the restriction

[1] Frederiksberg is under a separate local administration, but is in effect part of Copenhagen.

of members to one particular doctor. Apart from the societies which expressly provide some measure of choice for their members, societies as a rule are now prepared to appoint "supplementary" doctors for districts if it is alleged that the districts are too large or the number of patients too many for the number of doctors employed, or if frequent complaint is made of the doctor employed.[1]

The same doctor may act for many societies. Most of the societies are affiliated to the local federation of sickness insurance societies, and terms of service are arranged through the federation.

(*b*) *Provincial towns.*

Free choice is generally allowed, within limits. A member is allowed to choose at the beginning of each year by what doctor he will be attended. He is not permitted to change his doctor within the year unless there are special circumstances.

(*c*) *Rural districts.*

There is still a larger measure of free choice. Members are allowed to choose their doctor on the occasion of each illness, provided that he lives within a radius of 12 kilometres (about $7\frac{1}{2}$ miles). The system of free choice of doctor prevails in all the rural districts, with a few exceptions where the general conditions approximate to those of urban communities. Many parts of rural Denmark are very sparsely populated, and there may be but one doctor within reach, and even he may live a long distance away.

Free choice of doctor has only become so widely prevalent in recent years. Outside the capital towns the doctors have pressed for it. They are very well organised, as strongly organised as in Germany, and they can generally get their way.

The medical organisations do not seem to have taken any strong action in Copenhagen for free choice. The system

[1] See particulars in appendix XI. of the agreement between societies and doctors at Copenhagen.

of employing district medical officers has been long in force. The doctors in possession are many and their influence strong. The very fact that they are many mitigates opposition to the system.

At the same time, it has to be remembered that much the largest number of members are treated by a few doctors. Some interesting particulars are given in appendix X. respecting 66 of the societies affiliated to the Copenhagen federation. The report of the federation contains information of the number of members allotted to each doctor.—

195 general practitioners were employed by the societies, in addition to specialists.
53 of these had over 1,000 society clients each.
90 of these had under 500 society clients each.

It is important to note also that it is the younger doctors who are hardest hit by a system in which free choice is not allowed.

There is much disquietude at the results of giving free choice. As will be shown later, the cost of medical service has risen largely in recent years. It has risen more in provincial towns and in rural districts than in the capital towns. Part of the blame for the rise is laid on the free choice of doctor. As in Germany, it is alleged that some members go to the doctors who give them the treatment and the drugs which they desire, and who do not apply an exacting standard in certifying inability to work. Added to this, it is felt to be much more difficult to exercise control over the doctors. But, in considering the increase in cost of medical service, it has to be borne in mind that in recent years there has been an extension, not only of free choice of doctor, but also of the practice of paying the doctor according to the services rendered by him (per consultation, visit, etc.), instead of by capitation fee, and this change has contributed largely to increased costs. Special measures have been adopted by many societies to check abuses. These will be described later.

CHAPTER VI

Choice of Medical Practitioner

Conclusions

1. *In sickness insurance, free choice of doctor should be conceded.*

(*a*) In Germany and in Denmark the trend is steadily in the direction of free choice. True that the number of societies in which it is at present not granted is large. True also that in Germany, owing to the fresh antagonism engendered between societies and doctors by the advent of the new insurance law, the societies are taking a new stand against free choice. But a temporary set-back will not ultimately stay the steady flow of the main current. Society after society, especially large district societies, have conceded free choice, and the progress of the movement seems assured.

In Denmark there is free choice in nearly the whole country, except in Copenhagen and Frederiksberg. There it has not been established because the employment of district medical officers by sickness societies is of long standing, and medical opinion has not yet ripened to sufficient strength to break through the strong monopoly of the doctors in possession. But a change is probably only a matter of time.

(*b*) Doctors press for free choice, and if united have power to enforce it.

In Germany and in Denmark the doctors take their stand firmly in favour of free choice. Policy may hold their hands in some districts, but the

demands are pressed home at favourable opportunities. And although doctors who have a monopoly of insurance practice in a district may object to the invasion of their territory, in proportion as medical opinion becomes organised they find it difficult to withstand it.

There are many reasons why free choice is demanded by doctors; thus—

When district medical officers are employed, the majority of doctors, at least in urban areas, are excluded from the treatment of insured persons. The exclusion tells especially against young doctors, and, having regard to the increase in the number of doctors in recent years, a large proportion of doctors will probably be fairly young, especially if, as in Germany, there has been rapid growth of population. This partly explains the strength of medical organisations and the persistence of their demands.

It is alleged that medical service degenerates under a system of monopoly.

The doctors with monopoly have large numbers of patients. They treat them for low payment. Medical service under such conditions cannot be maintained at a high standard.

Further, any system which offers undue obstacles to the younger generation of practitioners tells against efficiency. These practitioners have the latest learning of the schools. They are acquainted with the most recent researches and the latest methods of treatment. A practitioner of the old school, if secure in his monopoly, will continue in the old rut. But if subjected to the competition of the younger members of his profession, he will be induced to keep himself abreast of recent developments in medical treatment. He will still hold the advantage of being well known in his district, which should give him no slight pull over his younger competitors, and his ripe experience should give him a practised instinct for treatment

which the mere learning of the schools can never give.

When one, or a few doctors, have a monopoly of medical insurance practice in a district, the rate of pay tends to be unduly low.

Monopoly gives each doctor a large number of clients. He consequently can rest content with a low rate of payment, a concomitant often being, as previously stated, a low standard of treatment.

Doctors object to the monopoly in itself, apart from its consequence in treatment or rate of pay, because it excludes large numbers of them from insurance practice. This has already been considered. The low rate of pay which tends to go with monopoly of insurance practice is important in the present connection, because there is a much smaller amount of aggregate remuneration to be distributed among doctors, and the profession as a whole may suffer.

(*c*) It is to the interest of the patient that free choice should be granted.

It is important that the patient should be attended by a doctor whom he trusts. Faith in the medical attendant plays an important part in cure. Further, if the patient has to go to a doctor whom he does not like, he may delay too long before seeking his services.

Nor is it in accord with modern democratic development that a person should be required to go to some one particular doctor for treatment. It restricts individual freedom, whereas the main trend of progress is towards the extension of freedom. It is reasonable to require that very strong reasons be adduced to justify placing such a restriction on individual choice.

Many arguments are brought against free choice of doctor. It is alleged, for instance—

That many doctors will be too complaisant in ordering drugs and other forms of treatment which please the patient, rather than such as are necessary; and, especially, that they will too readily give certificates of inability to work.

That the too complaisant will be patronised rather than those who give good treatment. Opponents of free choice contend that where this system prevails a few doctors get the lion's share of the patients. This contention, however, does not really tell against the system of free choice unless it is clearly shown that the doctors with a large number of patients get them for improper reasons.

One of the allegations of the sickness societies of Cologne during the time when unrestricted free choice of doctor prevailed was that insured persons often went, not to the doctor in whom they had most faith of cure, but to the doctor who would be likely to give them what they wanted. It was pointed out that, in 1906, in the case of certain of the societies, 7 per cent. of the general practitioners in Cologne who were open to treat members treated 31 per cent. of the patients who were certified as unable to work. It was stated also that cases had been known in which persons had gone to one doctor when they were not seriously ill but desired to have an easy leisure time with sickness benefit, and to another doctor when they were seriously ill.

That under a system of free choice uniformity of treatment is very difficult to obtain, and a fair measure of uniformity is important in the giving of certificates of inability to work, certificates which carry receipt of money benefit.

Under free choice some of the doctors treating patients will have stern standards, some lax, and the clients of the former will be penalised as compared with those of the latter.

That the cost of medical benefit becomes unbearable.

Not only are the direct payments to doctors for their own services likely to be very heavy, but even greater is the risk of heavy expenses on account of drugs and other requirements, and because of readiness in giving certificates of inability to work, with consequent money benefit. The experience at Cologne strongly emphasises this danger (see appendix IV.).

These contentions resolve themselves mainly into the question of control. In effect, they amount to the statement that, under free choice, adequate control over the doctors and their doings is not possible.

It is manifest that adequate control is imperative. Economy in the dispensing of benefits is essential to working-men's insurance. They cannot afford it otherwise. Free choice may be desirable from many points of view, but the societies must live before they can live well. They will have to reject free choice if free choice is not compatible with economy, just as a ship in a storm has to jettison even valuable cargo.

Is it then practicable to combine adequate control with free choice ? The question is considered in a later chapter, and it will then be shown how it may be done.

That chapter will also contain material bearing on the question of the kind of free choice that should be allowed. Obviously a member cannot be allowed unrestricted choice. He can only be permitted to requisition such services as will not mulct the society in more than certain costs. In Germany, as we have seen, what the doctors seek is organised free choice—in which the doctors, as an organised body, agree with the society as to the terms on which services shall be rendered. This form of free choice is almost sure to prevail.

Free choice is not without its advantages to the society. In so far as it brings more effective treatment and surer and speedier cure, there is a gain to the society not less than to the patient. And it is effective treatment that counts most in the end even from the financial standpoint.

2. *In insurance against disablement it is reasonable that the insurance authority should employ special doctors for examining claimants to pensions.*

(*a*) It is of special importance that there should be no doubt that the persons to whom pensions are granted are entitled to them.

It is of course important to make sure that persons suffering from sickness and certified as unable to work—and therefore entitled to money benefit—are rightly certified as such. But it is even more important in the case of persons certified for disablement pensions that there should be no doubt as to their right to benefit. The man suffering from sickness is under constant supervision, and the period for which he can claim is generally narrowly limited. The man certified as permanently disabled will receive his pension for the rest of his life, subject to any arrangements that may be made for the revision of his case.

In Germany, grave defects have arisen because certificates of disability have been too readily given. This has been largely due to the over-complacency of the insurance authorities, and to their administration of the law in a temper too favourable to the working classes in order to gain their goodwill. But it has been due also in part to the fact that certificates are accepted practically from any general practitioner who happens to be attending the claimant. The certificates are scrutinised by confidential medical advisers, and cases are examined by these officials when doubt arises. But obviously many cases not rightly entitled to a pension may pass through the meshes of such a net.

The German authorities have found it necessary to revise their cases very stringently, and large numbers of persons have been deprived of their pensions because further consideration has shown that they have no longer been entitled to them—has shown in

many cases that pensions should never have been given.

(*b*) Uniformity of standard is very necessary in the granting of pensions. Without uniformity there is injustice. In one place persons are given pensions; in another, persons in similar or perhaps even worse circumstances are refused them. The difference in treatment is not only unfair, but, an equally important consideration, rouses strong feelings of dissatisfaction.

If any general practitioner whatsoever is to be allowed to give certificates, it is almost hopeless to expect uniformity of standard. It can be secured only when a small number of doctors are employed for examination of claimants—doctors who are in close touch with one another and with some supervisory authority who can train them to the discipline of a common practice. The difficulty of obtaining a uniform standard is the greater because that which has to be certified is not very definite. Whether it is the German standard of inability to earn one-third of what can be earned by a person of similar station in good health, or whether it is complete disability, clearly there is ample margin for individual idiosyncrasies in certification.

Some measure of uniformity can of course be secured by the German system, under which the certificates of general practitioners are scrutinised by confidential medical advisers and doubtful cases examined. But so much depends upon the wording of the certificate, and that in turn depends so largely on the ideas and standard of the certifying doctor, that the degree of uniformity won in this way is not likely to be very great.

It is from the doctors that complaint is likely to be received if certificates from ordinary general practitioners are not accepted. It is partly to conciliate the doctors that

the German invalidity insurance authorities accept the certificates of ordinary general practitioners. But the matter is not of supreme importance to doctors. The total sums received for certificates are not very large. Freedom of choice in treatment of sick members of insurance societies should be their main objective. That is the matter of primary importance to them. That secured, it is scarcely worth their while to raise much question respecting disablement or invalidity certificates.

3. *If treatment by unqualified practitioners be allowed, it should be permitted only under strict guarantees and precautions.*

In Germany, as we have seen, this question has aroused much agitation. Homœopaths come within the ban of the orthodox to some extent, but it is especially to the nature-cure practitioners that their opposition is directed. Some of these practitioners are duly qualified medical men, but many are not, and even those who are qualified are apt to be regarded by their orthodox brethren as touting quacks or charlatans if they pursue their nature-healing as the sovereign remedy for disease.

It has been stated that the agreements made between some societies and organised doctors provide that treatment shall only be given by duly qualified practitioners, but some societies do not willingly surrender their privilege of allowing their members to receive other treatment if they wish to do so.

The new law is not quite clear on the matter. It provides that medical treatment within the meaning of the law shall be given only by qualified practitioners, but adds that the principal administrative authorities may determine how far other persons (*Hilfspersonen*) may give independent aid within the limits recognised by the State. It is therefore not clear how far the medical profession has wholly gained its demand that insurance practice be restricted to duly qualified practitioners.

There is obviously much to be said for the demand of the medical profession. The evils of unqualified practice are patent, though probably only partially realised by most persons. Medical treatment is not lightly to be undertaken. A long course of preliminary training is essential. A sensible person will generally only entrust himself to practitioners with this training and its proven acquisition.

But we have to reckon with ignorance, and the credulity which thrives on it. The quack always has a public ready to gulp down his loud promises. The problem of unqualified practice is in many ways grave. The agitation of the medical profession arises, not simply from its effect on them or from professional feeling, but also because they know the harm which is being done.

With these facts in mind, the proper course may seem to be the complete prohibition of unqualified practice, at least in insurance. Some may hesitate to go so far as this, not because of any partiality for unqualified practice, but because they are not certain whether this is the best way to attack the problem. The following appear to be the principal considerations which may throw doubt on the policy of complete prohibition :—[1]

(*a*) It may be urged that it is not justifiable to require a man to go to a qualified practitioner for treatment if he wishes to do otherwise. Insurance casts its net wide. It tries to catch nearly all the working classes. There is, therefore, the more reason for giving scope for individual likes and dislikes. Not that an insurance society should be compelled to allow a member unqualified treatment at his wish, but that if the man did find a society which would venture to grant him the liberty, he should not be debarred from receiving it.

(*b*) Any professional body must almost inevitably be somewhat conservative in its own business. The

[1] With some German societies two other considerations weigh : (i) the possible use of the unqualified person when there is conflict with doctors, (ii) the saving on drugs in the case of nature-treatment.

more closely organised it is, the less tolerant is it likely to be of the new idea. This is a reason for not making its monopoly too tight. Not all unqualified practitioners are self-seeking charlatans. Occasionally one may come with a new idea, a little crude perhaps, which contains the germ of great benefit to mankind. And it is the new idea which counts most for progress. Therefore it is contended, because of the possible good, it is well to give some measure of liberty even to the unqualified.

(*c*) Some consider that the best way of combating the evils of unqualified practice is not by stern restrictions, but by publicity and education. Not a little of the mischief which is now being done would probably be prevented by more publicity respecting methods and wares. And since ignorance with its resulting credulity is the ground on which the tares root and flower so freely, the crucial need is to attack the ignorance. The very imposition of restrictions might be a hindrance to true progress, and might check wiser measures. Restriction may leave the man very much as he was, may not even much change his conduct. His failings may still continue, but underground. What is needed is that he be enlightened, and that his habits of mind be changed, and this can only be effected through education, an education which by going to the root of the problem will not only stay the evils of unqualified practice, but will bring higher standards generally in matters of health and treatment.

But even if it be considered that on the whole this is the best procedure, and that it is not expedient absolutely to prohibit unqualified practice, any such practice should clearly be hedged round with safeguards, especially in insurance to which employer or State contributes, and should be allowed only under strict guarantees and precautions.

CHAPTER VII

Remuneration of Medical Practitioners

GERMANY

Sickness

There is great diversity in the methods of remunerating medical practitioners, which is not unnatural, seeing that it is left to each society to make its own arrangements.

Doctors prefer payment by fees according to services rendered—so much per visit, consultation, &c. The Governments of several of the German states have issued tariffs of fees for medical services. These are not generally binding, except that, in the absence of other agreement, they serve to decide what the payment should be. The rates differ according to the station of the patient.

Doctors urge that they should be paid at the minimum rates provided in these tariffs. They would be well satisfied if they could achieve this, even though they declare that the lowest rates of the tariff provide only a scale applicable to the very poor. At present the payments generally received from sickness societies work out at rates much below what is contained in the state tariffs. Thus even in the case of the Leipsic district society—whose doctors are better off than in many places—the remuneration paid worked out in 1911 at less than 62 per cent. of what would have been received by the doctors under the medical tariff.[1]

There are strong objections from sickness societies to the payment of remuneration directly according to services rendered, and this method of remuneration does not prevail very widely, except in the case of payment to specialists.

[1] The tariff allows 1s. for a consultation, with larger amounts for other services.

Most of the large societies pay an annual capitation fee—so much per member. This form of payment can be adopted whether one doctor be employed or whether there be free choice of doctor.

But where there is free choice of doctor it is possible to combine capitation payment for the society with payment according to services for the individual practitioner. The society may hand over to the doctors the total amount of the capitation fees, and the doctors may then arrange to divide the amount among themselves in such manner as seems good to them. In such a case, the society (or a federation of societies) deals primarily, not with individual doctors, but with an association of the doctors. This, as will be more fully shown later, and the dealing with the doctors as a corporate organisation, opens up the way to the solution of many difficulties which press hardly on insurance.

Some system of the kind described is being increasingly adopted by the large societies. Particulars respecting the arrangements at a number of places are given in appendices at the close of the book.

One of the best examples is that at Leipsic. The terms of medical service for the 200,000 members of the Leipsic society are arranged between the society and the two medical district associations in the area covered by the society, that for Leipsic town and that for Leipsic rural district. These medical associations are semi-official bodies to which every civil doctor belongs, and are distinct from the voluntary organisations of the doctors to which reference is made in appendix I.

The agreement provides that the society shall pay to a committee of the doctors quarterly capitation fees to cover cost of medical service. The total amount of the fees is then divided out among the practising doctors in proportion to the sums they would have received had they attended the members as private patients, according to a tariff of charges agreed upon between the society and the doctors, practically according to the minimum charges of the state tariff. Thus suppose that under this tariff a

doctor would have received £200 for services rendered by him during a period, and suppose the sum total of all the amounts which the doctors would have so received was £100,000, but that the total amount of the capitation payments only comes to £60,000 ; then the doctor would receive $\frac{60,000}{100,000}$ of £200.

Leipsic is but one type of organisation. There are other varieties. Thus at Munich, as previously mentioned, the agreement is made between the society and a local medical association formed to uphold the free choice of doctor. Capitation payments are made by the society to this association, and divided out by the latter among the practising doctors. In the division of the spoils a surgery consultation during the day counts as one point ; a surgery consultation at night, two points; a visit during the day, also two points ; for a night visit a special fee is provided.

At Frankfort-Main the arrangements are similar to those at Munich. There the agreement is made between a federation which comprises 37 sickness societies—and embraces district, establishment, guild,. and voluntary societies—and a local voluntary organisation of the doctors. An interesting provision in the Frankfort agreement is that a doctor is not allowed to commence services until six months after his application, and in the course of the first three months of this six-months waiting period he must attend sittings of the confidential medical advisers and of the committee of the doctors who check prescriptions, in order that he may become well acquainted with the work and obligations of a doctor attending insured patients. This is an interesting recognition of the need of some special training for doctors of sickness societies, a need which is urgent.

Of course, under arrangements similar to those described, the method under which the total amount available is distributed between the participating doctors can be indefinitely varied to suit the needs and idiosyncrasies of local conditions. In some cases distribution is made according to number of cases attended.

The capitation payment may cover only ordinary services. For special services—operations, X-ray examinations and the like—special fees may be paid to the doctor rendering them, outside the capitation payment. Thus the agreement between the district society of Munich and the local medical association for the free choice of doctor, provides for special payment in respect of no less than 146 special services; the amount of the fee runs from 1s. to as much as 50s. in some cases. It is usual to pay special allowances to doctors who have to travel more than a certain distance to attend their patients (mileage money); in such cases, however, the society may make it a condition that the patient shall obtain the services of one of the doctors residing nearest to him.

On the other hand, payment for operations may be included in the capitation fee. Thus a Berlin association of doctors counted one point for a consultation, two for a visit, two to ten for operations, according to their severity, and then divided out the aggregate sum to each doctor according to the number of points he had accumulated. But this association also provided that certain services should be paid at fixed sums—night consultation, 2s.; night visit, 4s.; difficult midwifery cases, 10s.

The details given at the close of the chapter respecting the remuneration paid by some societies to doctors will give information respecting the total amount paid in extra fees in the cases mentioned.

At the opposite pole to the payment of doctors by fee according to services rendered is the employment of doctors at fixed salaries. This system goes naturally with the refusal to members of choice of doctor. It is the system adopted by the Dresden District Society which, as previously stated, is the standard-bearer in Germany, among the district societies, in the struggle against the free choice of doctor. In the case of the dependants of members residing outside the area for which district medical officers have been appointed, the society pays certain fees for, or

towards the cost of, medical services at rates stipulated in the rules (E.).[1]

It does not follow that, where there is not free choice of doctor, the medical attendant is paid by salary. He may be paid so much per member or so much per case. There are also other varieties of payment. Thus some doctors are paid so much per cent. of contributions received or of benefit paid, while a doctor of one cement-works society is paid so much per ton of cement produced. This system is very similar to that for the remuneration of colliery doctors in this country who have been paid so much per pound of the workmen's earnings, the earnings of the coal-hewers being determined by the amount of coal they turn out.

The Hamburg society for domestic servants shows still another variety. The municipal authorities yearly fix a lump sum which they will pay for medical treatment of insured persons, this sum to be divided among doctors in proportion to services rendered. They then advertise for applications from doctors on these terms. There is no lack of applicants and the doctors seem satisfied with the terms. This, in effect, is the fixing of the amount to be paid by the number of members, and the division of this amount, by the insurance authority itself, among the participating doctors in proportion to their services.

Where there is free choice of doctor, it does not, of course, follow that the aggregate remuneration will be evenly divided among the doctors any more than it is so now in private practice. One of the retorts of the sickness societies at Cologne was that experience showed during the period from 1904 to 1909, when the doctors had the upper hand of the societies and free choice of doctor prevailed, that the lion's share of the spoils went in fact to a few doctors, to the more complaisant ones, say—of course the opponents of free choice.

In the report of the Kiel District Society for 1910 particulars are given of the distribution of income among the

[1] The references are to notes at the close of the chapter.

34 doctors who treated patients of the society. (Three other doctors were employed during part of the year.)

The average income of the doctors from the sickness society came to £200.

1	doctor	received over £600.	
2	doctors	between £500 and	£550.
2	„	„ £300 „	£400.
9	„	„ £200 „	£300.
8	„	„ £100 „	£200.
12	„	under £100.	

Three of the doctors received a third of the total income.

In the year 1910 the sickness societies of Germany, including the voluntary societies which fulfil the requirements of the compulsory insurance but excluding the miners' societies, spent the large sum of over £3,800,000 in payments for medical service, equivalent to an average of 5s. 10d. per member, exclusive of institutional medical service.

The following are particulars for 1910 of—

(*a*) the average expenditure per member on medical service,

(*b*) the percentage of the expenditure under this head of the total expenditure,

in some of the large district societies—

(*The Numbers in Brackets show the Membership.*)

		(*a*) s.	(*a*) d.	(*b*) Per cent.
Leipsic	(182,898)	8	2	21
Munich	(125,142)	6	8	15
Dresden	(119,419)	6	4	20
Hamburg (employees)	(55,897)	8	3	21
Cologne (miscellaneous)[1] ...	(25,634)	5	3	16
Königsberg	(23,200)	6	6	19
Kiel	(20,844)	8	8	19

Of these societies, in only one case was the expenditure under 6s., and in three of the seven cases it was over 8s.

[1] This society (*Orts-Krankenkasse für die in stehenden Gewerbebetrieben etc. beschäftigen Personen*) includes among its members—Males: apprentices, packers, house servants, business assistants. Females: apprentices, day helpers, laundry workers, business assistants, workers in cardboard box factories, &c. It includes, that is, workers in several occupations not requiring much skill and in which remuneration is generally low.

Generally, the expenditure on domiciliary medical service was about one-fifth of the total expenditure.

The differences in rates of expenditure are very marked. They arise partly from differences in benefits given, but also partly from differences in rates of remuneration to doctors.

It is of interest to compare the expenditure of the different kinds of societies. Particulars are given at the close of this chapter (A). The average expenditure is highest in the establishment societies, which, on the whole, appear to give the most liberal benefits, and lowest in the communal insurance funds, which gave the least. In 1910 the average expenditure per head was 7s. 11d. in the establishment group, 5s. 5d. in the district group, and 4s. 2d. in the communal funds.

The expenditure differs very much in the different societies. This will be manifest from the particulars given at the close of the chapter (D) respecting the average expenditure per member in 1909 of the several societies in the Cologne district. The largest amount was 20s., and many societies averaged over 10s. At the other extreme, one society did not spend any money on domiciliary medical treatment, but had a heavy outlay on institutional benefit, and several societies spent less than 5s. per member. The average in all the societies was approximately 7s. The variations are much larger among establishment societies than in any other group; the circumstances of the establishment societies depend more on the nature of the employment and on what is done by the employer.

The following points should be borne in mind in interpreting the foregoing statistics of expenditure.—

1. The expenditure covers only medical service.

   Medical and surgical requirements are separately charged. Doctors are not allowed to dispense.

2. It only extends for the most part to domiciliary treatment.

   Treatment at hospitals, convalescent homes, and the like is charged under the head of institutional

treatment. But the cost of some treatment at private clinics may be included under the head of medical service (see, for instance, the details given at the close of the chapter of the items included in the expenditure of the Leipsic and Munich societies).

3. The period for which benefit is given is limited.

This matter has been considered in the first chapter, in which information is also given of the conditions under which the invalidity insurance authorities give assistance.

4. The benefit may include medical treatment of dependants.

This matter also has been referred to in the first chapter. It must be remembered, as already indicated—

(*a*) that the provision of medical treatment for dependants is optional ;

(*b*) that it may be given only on payment of special contributions, and that few members may take advantage of the opportunity to provide treatment for dependants on the terms offered.

All the societies included in the table above, except that of Munich, give medical benefit to dependants ; but that of Cologne (miscellaneous) gives it only on payment of special voluntary contributions.[1]

When family benefit is granted as part of the ordinary benefit the additional medical work may be heavy. This is shown by the particulars given at the close of the chapter respecting the cases attended by the doctors of the Leipsic society (F). Roughly, 550,000 cases of sickness were attended in 1910, and of these 250,000 were cases of sickness of dependants. The same fact is illustrated by the capitation rates paid for members with, and for members without, dependants. For the former, the Leipsic society pays 7s. 3d. (later 7s. 6d.) a year, for the latter 5s. The differences seem generally to be even

[1] Some information will be found in appendix IX. of the practice of 28 large societies. As regards the Cologne society, only a few members participate : the sum paid for medical service to dependants was under £180 in 1910.

greater. Thus at Stuttgart the rates are 10s. 6d. (later 12s. 6d.) and 4s. 2½d. (later 5s.). In the report of the Kiel District Society it is stated that of the average 8s. 8d. per member spent on medical service in 1910, 2s. 11d. was in respect of dependants of members: the corresponding figures for 1909 were 8s. 2d. and 2s. 9d.[1]

5. The cost of dental treatment is included.

The extent to which dental treatment is given varies. It has not been clear whether such treatment was obligatory, and some societies have not given it. But many societies incur a large expenditure under this head. Thus the Leipsic society spent nearly £4,900 in 1910, an average of over 6d. per insured member, and the Munich society over £3,900.[2]

The new law contains special provisions relating to dental treatment.

6. There may be included in cost of medical service some expenditure incidental to service by the doctor himself.

This occurs, for instance, in the case of massage and Röntgen ray treatment. But such service is essentially part of the cost of medical treatment, and is not a large item.

7. The cost of the employment of confidential medical advisers is included.

These officials are used, not for treatment, but for advising the society and for assisting in control. The expenses of control committees are also included. These charges are relatively small.

8. Facilities are generally available for sending cases to hospitals when such treatment is desirable.

Germany is studded with municipal hospitals. There are also many other hospitals. Cases are freely sent there for treatment—too freely, it is not unseldom declared. This, of course, largely relieves the doctors, and is a heavy source of expense to the societies—and they do not bear the whole cost. This matter is further considered in chapter XVI.

[1] Out of the 8s. 2d. per member spent by the Leipsic society in 1910, 1s. 5d. (17 per cent.) is stated to have been for medical service to dependants.

[2] See appendix IX., column S (*b*), for some further particulars.

There has been a very large increase in the expenditure on medical service. At the close of the chapter particulars are given of the expenditure during a series of years in the different kinds of societies in the whole country (A) and, in particular, in the Leipsic society (B). Taking all the societies, there was spent on the average per member—in 1883, 2s. 4d.; in 1898, 3s. 4d.; in 1910, 5s. 10d. In the Leipsic society, the amounts were 3s. 8d., 5s. 4d., and 8s. 2d. respectively. There have been similar increases in other societies. Thus, the Munich society spent 5s. 3d. in 1904, 6s. 8d. in 1910.

There are several causes which have contributed to this large rise—

1. The period for which benefit is given has been extended.

   Up to 1904 the minimum period of benefit was 13 weeks; since then, 26 weeks. Most of the societies confine themselves to the minimum. But a considerable number give longer benefit, and the practice of doing so has become more common.

   But the lengthening of the period of benefit does not make so great a difference as might at first appear. Most cases of illness terminate before the first 13 weeks. Information given in the report of the Leipsic society for 1910 shows that over 96 per cent. of the cases treated in that year in which the patient was unable to follow his employment terminated within that period.

2. The scope of medical benefit has been extended.

   More is given to members. Medical treatment has become more elaborate, a fact illustrated by the addition of one year to the medical curriculum. More use is made of specialists. In 1910 the Leipsic society employed 130 specialists and 24 dental surgeons, out of its total of some 400 doctors; and the Dresden society, 64 out of its total of 226. A list of the specialists employed by the latter society is given at the close of the chapter (H).

   The general employment of specialists has not the same significance as it would have in this country. It

is more usual for doctors to specialise in Germany. A doctor may be a general practitioner and at the same time a specialist in some particular department. Still, the more general employment of specialists does represent an extension of benefit.

Another direction in which treatment has extended is in the more liberal provision of dental treatment. More use is also made of private clinics, while some societies have special institutions, such as the Zander Institute, used for giving orthopædic and other treatment, of the Leipsic society. This institute was made as a gift to the society, as have been some of its convalescent homes, and has been extended by the society.

This widening of the scope of medical treatment is partly due to the broadening of medical notions as to what is required for proper treatment, partly also to the broadening outlook of sickness societies as to the needs of their members. But "*es kostet viel Geld*," as the managers of sickness societies uneasily tell the inquirer.

3. It is more usual to give treatment to dependants as part of the benefit.

This question has already been considered.

4. The average number of days per member for which benefit is given has increased.

The following figures show the average number of days for which money benefit was paid or institutional treatment given (a record is not generally given of the duration of other benefit) in—

(*a*) the district societies,
(*b*) the establishment societies, and
(*c*) in all the societies and the communal insurance funds of Germany for a series of years.

	(*a*)	(*b*)	(*c*)
1888	5·3	5·9	5·5
1893	6·7	7·2	6·5
1898	6·3	6·8	6·1
1903	7·4	7·7	7·0
1908	9·0	9·0	8·4
1910	8·6	8·6	8·0

The investigation of the reasons for this increase is most important: how far it may be due to the extension of the period of benefit; the bringing of new classes into the scheme of insurance; more thorough treatment; malingering or valetudinarianism, &c. But this is not the place to go into the question.

5. There is no doubt freer resort to medical treatment at the expense of the insurance authorities.

   This is due in part to the fact that insured persons have become better acquainted with their rights. It is also, no doubt, due in part to the fact that insured persons run to the doctor more readily for minor ailments; this in some respects is good, in other respects may be pernicious.

6. Most important of all is the heavy rise in the rates of remuneration paid to doctors.

   The rise has been general, and has been enormous. Thus the Leipsic society paid a capitation fee of 3s. 3½d. per member in 1888; in 1910 they were paying 5s. for a member without dependants, 7s. 3d. (to be raised to 7s. 6d. in 1914) for a member with dependants. The new agreement made between societies and doctors at Stuttgart in 1910 provided that the rate for members with dependants should be raised immediately from 10s. to 10s. 6d., and by increments to 12s. 6d., or 13s. 6d. in certain conditions; and for members without dependants from 4s. to 4s. 2½d., rising to 5s. (appendix VIII.).

   The increase has been due partly to the extension of insurance to more and more members of the community, with the result that the doctor has to press more strenuously for a "living wage" from his insurance patients. At the same time he has organised himself sufficiently well to press with fair assurance of success. The matter will be considered more in detail in the chapter of conclusions.

7. Some part of the rise in remuneration has been nominal rather than real.

   The cost of living has risen, and the doctors reasonably require some compensation for this.

> And not only has the cost of living risen, but the standard of living is higher in the social class to which the doctor belongs. In other walks of life, the commercial especially, rates of remuneration have increased. The doctor has to keep pace with members of the class in which he mixes, and though he avow, not without truth, that his is not a commercial business, still he rightfully expects remuneration which will enable him to maintain his station.

One of the most difficult questions which arises in insurance is that of the class to which insurance shall be applied—or rather, so far as this section is concerned, the class for which treatment shall be provided on ordinary insurance terms.

This question is very acute in Germany. Under the old law, certain classes of persons are not compulsorily insured if their means exceed 2,000 marks (about £100) a year. Under the new law, the limit is raised to £125 a year for sickness insurance. The story of the adoption of this higher limit is interesting. It was not originally inserted in the Bill, but was adopted in committee. It was later rejected in committee, but was again inserted, on third reading, while the Bill was going through the last stages.

The higher limit was strongly supported by the social democrats. They pressed, indeed, for a much higher figure. It was urged that, apart from general social reasons in favour of raising the income limit, the heavy increase in cost of living justified a substantial rise. The doctors stoutly opposed any change, and they are still clamorously protesting. They declare that they will not treat on ordinary insurance terms any person brought into the insurance scheme under the new law with an income of over £100 per annum, and a resolution to this effect was adopted at the general meeting held at Stuttgart in June, 1911. The doctors further declare that, owing to the changes effected when the amended Act comes into force, the existing contracts will be automatically terminated.

This gives them the opportunity for concerted action over the whole of Germany, and opens a road, not only to negotiations as to the income limit, but also as to other vexed questions, especially the free choice of doctor and better rates of remuneration, negotiations to be pressed home, if expedient, by organised refusal to give service. The opponents of the doctors declare that the clamour respecting the income limit is only a pretence for wringing new concessions from the sickness societies.

There appears to be no clear information as to the number of persons who will be brought within compulsory insurance by the raising of the income limit. One writer on the side of the establishment societies puts the number as low as 300,000; another, from the doctor's side, estimates it as at least 1,500,000. The former estimate seems approximately accurate. The doctors assert that, with the new income limit of £125 per annum, there will be whole districts where practically every person will come within the insurance scheme and no private practice will be left for the doctors.

The doctors feel the need of action with regard to the income limit the more strongly because, under the German law of compulsory insurance, whatever a man's income, contributions are not levied on more than 6s. a day, and therefore there is the less margin for increased payments for medical service.

The situation is critical. The doctors are too well organised and too well practised in agitation during the past troublesome years to be ignored. If they put their threat into effect, they will fight with good prospects, provided that they close their ranks firmly. Unless some compromise can be effected there are probably stormy times ahead.

In the case of persons who are not compulsorily insured but who are entitled to become voluntarily insured if they choose, the new law allows sickness societies to vary the benefits, with the consent of the higher insurance authorities, so that the members shall receive only medical treatment or, on the other hand, only money benefit. The doctors consider this provision useful, as it will enable them

to press for the latter alternative so that insured persons of this class may be medically treated as private patients.

Another question which arises with regard to income limits is that of the person who is insured because at the time his income is within the limit fixed, but who later wins his way to an income beyond the limit. Under the old law, in such a case the person was allowed to continue his insurance, regardless of the amount of his income. The new law provides that he may continue his insurance so long as his income does not exceed £200 per annum. If this amount is exceeded, he can no longer be insured under the workmen's insurance law. Doctors regard this as a step in the right direction. But they consider the limit too high and agitate for a maximum of £100 per annum; and they also assert that there is no systematic means of ascertaining when a person's income exceeds £200 per annum. They point out that, as 6s. a day (say about £90 a year) is the maximum wage on which contributions are made under the insurance law, the sickness societies will not be in a position to know when a member's income exceeds the £200 a year.

A.—Average Cost per Member of Medical Service in all the German—

D. District sickness societies.
E. Establishment sickness societies.
C. Contractors' sickness societies.
G. Guild sickness societies.
Cm. Communal insurance funds.
V. Registered voluntary aid societies.
S. Registered State aid societies.
T. All societies and insurance funds.

Year.	D.	E.	C.	G.	Cm.	V.	S.	T.
	s. d.	s. d.	s. d.	s. d.	s. d.	s. d.	s. d.	s. d.
1888	2 2	3 9	3 7	1 9	2 0	0 9	0 10	2 4
1893	2 8	4 4	5 1	2 4	2 4	2 4	2 2	3 0
1898	3 0	4 8	5 9	2 10	2 4	2 10	2 7	3 4
1903	3 8	5 6	8 4	3 6	2 10	3 4	3 2	4 0
1908	5 1	7 5	7 0	4 10	3 10	4 8	4 0	5 6
1910	5 5	7 11	7 1	5 3	4 2	4 11	4 3	5 10

B.—Leipsic District Society: Payments for Medical Service

Year.	Average per Member. s. d.	Per Cent. of Total Expenditure.
1888	3 8	... 19·0
1893	4 6	... 20·0
1898	5 4	... 21·0
1903	6 2	... 21·0
1908	8 6	... 22·0
1910	8 2	... 21·0

C.—Annual Capitation Fee per Member paid to Medical Practitioners by the Leipsic District Society

s.	d.	
3	0	to the end of 1887, attendance on dependants included.
3	3½	from 1 January, 1888, „ „ „
3	7¼	„ 1 October, 1888, „ „ „
3	10¾	„ 1 July, 1896, „ „ „
4	2½	„ 1 October, 1897, „ „ „
4	6	„ 1 October, 1898, „ „ „
5	0	„ 7 May, 1904, without attendance on dependants.
6	6	„ 1 May, 1905, attendance on dependants included.
7	3	„ 1 January, 1911, „ „ „
7	6	„ 1 January, 1914, „ „ „

For a member without dependants the capitation fee is still 5s. The present agreement is in force until 1916.

In addition, special payments are made for midwifery cases (where medical service is required: ordinary midwifery cases do not entitle a member to medical benefit), and for special electro-physical treatment which has been sanctioned. Mileage money is also paid in some cases.

D.—Cologne District: Expenditure of the Several Societies on Medical Service

Number of societies with average expenditure in 1909 as shown in the first column—

D. District sickness insurance societies.
E. Establishment sickness insurance societies.
G. Guild sickness insurance societies.
T. All the societies.

	D.	E.	G.	T.
20s.	—	1	—	1
15s. and over, under 20s. ...	—	5	—	5
10s. „ „ 15s. ...	—	7	1	8
7s. „ „ 10s. ...	3	6	2	11
5s. „ „ 7s. ...	11	36	1	48
3s. „ „ 5s. ...	1	6	2	9
Under 3s.	—	1	—	1
Total	15	62	6	83
	s. d.	s. d.	s. d.	s. d.
Average expenditure	6 3	8 5	7 2	6 11
Highest „	8 6	20 0	10 3	20 0
Lowest „	4 7	nil[1]	3 8	nil[1]

[1] The society with no expenditure on domiciliary medical service had an expenditure of 29s. per member on institutional benefit.

E.—Payments made by the Dresden District Society in respect of Medical Service rendered to Dependants of Members entitled to Free Treatment who live outside the Dresden Medical District

For a surgery consultation	9d.
For a visit	1s.
For a visit outside the township of the doctor, according to the distance	From 1s. 6d. to 3s.

(The member is only entitled to the fees payable for the services of the nearest qualified doctor.)

F.—Details of Payments made in the Year 1910 to Medical Practitioners by Some Societies

(1) *Leipsic District Society*

	£	£
Total amount paid		74,531
This amount included—		
Capitation payments	56,101	
Special fees to the society doctors	3,660	
Payments to practising doctors employed at salaries (under old contracts)...	551	
Payments to society doctors outside the district ...	4,215	
Payments to doctors other than society doctors ...	1,719	
Payments to polyclinics	1,329	
Payments to dental surgeons	4,861	
Payments for massage treatment	396	
Payments to the Zander Institute (for Röntgen-ray treatment, &c.)	314	
Payments to doctors in respect of other expenses ...	212	
Repaid to members in respect of payments made by them for medical treatment...	410	
Payments to the confidential medical advisers ...	763	

The total payment was equivalent to 8s. 2d. per member.

(2) *Munich District Society*

	£	£
Capitation payments to the Munich Medical Association for Free Choice of Doctor (at the rate of 4s. 3d. per insured member)		26,852
Payments to the Association for services specially remunerated	7,597	
Payments to doctors not members of the Association (urgent cases)	11	
Payments to doctors outside the district	792	
Payments for surgical services in bath establishments ...	446	
Payments for massage	222	
Payments for orthopædic treatment	330	
Payments for hot-air treatment	59	
Payments for Röntgen-ray treatment	20	
Various expenses	3	
		9,480
		36,332

	£	£
Payments for control inquiries of the doctors' committee	312	
Payments for control inquiries in accident cases ...	53	
		365
Payments to confidential medical advisers		870
		37,567
Payments in respect of dental treatment—		
To the Association of Specialists for Diseases of the Teeth and Mouth	408	
To the Department for Free Choice of Dental Surgeon	1,086	
To dental surgeons outside the district	29	
To the Dentists' Association	212	
To the Local Association of Dentists	1,602	
To dentists outside the district	18	
To bath establishments	388	
To confidential medical advisers for diseases of the teeth and mouth...	150	
For examination of accounts for dental treatment ...	30	
		3,923
		41,490

The total payment was equivalent to 6s. 8d. per member.

(3) *Königsberg* (*Gemeinsame*) *District Sickness Society*

	£	£
Capitation payments	6,477	
Payments for midwifery cases	151	
Payments for loss of time and mileage	73	
Payments for Röntgen-ray treatment	116	
Payments for treatment of speech defects	15	
Payments to doctors outside district...	59	
Payments to dental surgeons	509	
	7,400	
Payments to confidential medical advisers	215	
		7,615

The total payment was equivalent to 6s. 6d. per member.

G.—Leipsic District Sickness Society: Particulars of Services rendered by the Medical Practitioners of the Society in the Year 1910

Free medical treatment was given to—

Members ... ... 76,572 cases of members who were unable to follow their employment.
212,877 cases of members who were able to follow their employment.
140,021 male members.
72,856 female members.

Total 289,449

Dependants of members 248,760 { 79,235 wives. 161,948 children. 7,577 other dependants.[1]

[1] In this society dependants may include, under certain conditions, children under 16 years, wife (or husband), parents, parents-in-law, grandparents.

H.—Specialists employed by the Dresden District Society

(119,419 Members)

11	specialists	for	eyes.
10	„	„	ears, nose, and throat.
8	„	„	surgery.
8	„	„	gynæcology.
5	„	„	the skin, &c.
4	„	„	the nerves.
2	„	„	digestive organs.
3	„	„	orthopædics.
13	„	„	teeth.

Masseurs and masseuses are also employed.

I.—Invalidity Insurance : Payments for Medical Certificates of Invalidity

Nominally, the obligation is on the claimant to produce evidence, at his own cost, of invalidity. At first some of the Invalidity Insurance Authorities required claimants to produce medical certificates accordingly at their own cost. But difficulties arose because of the poverty of claimants. Now, the Invalidity Insurance Authorities generally pay the whole, or at least one-half, of the cost of initial medical certificates. (The claimant may afterwards have to undergo, at the expense of the Insurance Authority, examination by a confidential medical adviser.) The Invalidity Insurance Authorities pay even when the claim (to pension or treatment) has not been substantiated, if the claim has been made in good faith. Most Invalidity Authorities pay for certificates from any doctor chosen by the claimant, but some authorities pay only for certificates obtained from the doctor who has been treating the claimant, or even only from the confidential medical adviser of the local insurance body.

As to the amount paid, some Invalidity Insurance Authorities pay one uniform fee (*e.g.*, 6s.) for each certificate ; others pay different fees according to the certificate and examination required in the case.

CHAPTER VIII

Remuneration of Medical Practitioners

DENMARK

The law requires that recognised societies shall give medical treatment as part of benefit. Special permission may be given to societies to make other arrangements, such as providing a larger money benefit, without medical treatment; but this is only allowed when there is some special difficulty in providing medical benefit in kind. The law also provides that if a society before recognition only paid for part of the cost of medical service, the Government, on the application of the society, may allow it to continue this practice. Some societies have taken advantage of this provision. A Danish writer on insurance regrets that applications for permission to continue such special arrangements have not been more numerous, for it is found that requiring a member to pay out of his own pocket for part of the cost of medical benefit is an excellent check on abuses.

It has been stated that the terms of medical service are arranged between the federations of sickness societies and the local association of doctors. Payment is either by capitation fee or by fees according to particular services rendered. Generally, it may be said that the former method prevails in the larger urban districts, the latter in the rural districts. At some places the doctors have been pressing more of recent years for payment by fees and have gained their object.[1]

At Copenhagen, the societies paid a capitation fee of 4 crowns a year (about 4s. 5d.) for cost of medical service.

[1] The medical associations have tariffs, from which a discount may be allowed to the societies, *e.g.*, 25 per cent. in one district, 33⅓ per cent., on certain charges, in another.

This was increased to 4s. 8¾d. from 1912, and will be further increased to 5s. in 1915. An interesting provision is made for specialist services. Out of the annual capitation payment per member, 70 öre (about 9¼d.) appear to be allotted for payment of specialists for diseases of the eye and of the ear, nose and throat, and for massage treatment. From 1912, there are also to be provided such examinations by specialists as the society doctor may consider necessary and as may be done without sending the patient to a hospital. The societies have to pay for substitutes when the society doctors are not available.

Relations between doctors and sickness societies are less strained than in Germany. The doctors are very well organised, and can generally get good terms if they strive for them with sufficient unity.

In the earlier years of the State-assisted insurance, there were many hot disputes between doctors and societies. In later years, at only one place, Aarhus, has disagreement become very acute. There the doctors ultimately gained their object, and the societies had to concede the rate of remuneration demanded—5 crowns (about 5s. 7d.) per member per annum for general medical attendance.

In the year 1909 the sickness societies paid over £140,000 for medical treatment, which was an average of 4s. 7d. per member, and 37 per cent. of the total expenditure. The medical cost is proportionately less in Copenhagen and Frederiksberg than elsewhere. In 1909 the average per member was: in Copenhagen and Frederiksberg, 4s. 3d.; in the provincial towns, 5s. 1d.; in the two groups of rural districts, 4s. 6d. and 4s. 9d. respectively. There are a number of causes which contribute to this result, thus—

(*a*) Many of the rural districts are very sparsely inhabited, and doctors may have to go long distances to attend their patients, which, of course, adds to the expense.

(*b*) There is generally more and readier hospital accommodation in the large urban areas than in other parts of the country, and therefore in the latter places

doctors have to treat at home cases which might otherwise have been sent to a hospital.

(*c*) The prevailing opinion appears to be that the chief cause lies in the extension outside the capital towns of the practice of allowing free choice of doctor and payment by fees according to services rendered.

Medical expenditure forms a much larger proportion of the total expenditure in rural than in urban districts; thus—22 per cent. in the capital towns, 57 per cent. in the rural districts of Jutland (C). The reason is partly the higher cost of medical service in the rural societies, but principally the fact that smaller amounts are generally given in money benefit by the latter than by urban societies, especially societies in the capital district.

Appendix X contains some details respecting the expenditure on medical service of societies affiliated to the Copenhagen federation of sickness societies.[1] Of the 66 societies of which particulars are given, nearly two-thirds paid between 4 and 5 crowns (4s. 5d. and 5s. 7d.) per member; nearly all the other societies paid between 3 and 4 crowns (3s. 4d. and 4s. 5d.). One society paid the very high amount of nearly 12s.; but this was wholly exceptional, and is said to have been partly due to payment for medical treatment according to services rendered.

In interpreting the figures of expenditure, considerations similar to some of those stated in the case of Germany have to be borne in mind: that the cost of drugs, &c., is excluded; that the period for which benefit is given is limited (see chapter II, p. 13); that only the cost of domiciliary treatment is included; and that there is generous provision of hospitals, especially in Copenhagen and district.

Two matters require special mention—

1. Insurance automatically carries medical treatment for children of a member, under fifteen years of age, living with, and dependent on, him.

This obviously adds considerably to the medical work.

[1] Appendix XI contains a summary of the agreement between the federated societies and the medical association at Copenhagen.

2. Women may be insured who are not in paid employment.

This is in contrast to Germany, where only persons employed are, as a rule, directly insured under the compulsory insurance laws. In Denmark, it is quite usual for a man's wife to join the insurance society, as well as the man himself. She counts equally as one in the total of membership in the insurance statistics. There are now more women than men insured in recognised societies.

This fact may tell against the doctor in one way. If the wife is insured, he only receives the payment allowed by the society. If she were not insured, he would attend her as a private patient, and his charges might be higher. On the other hand, where a capitation fee is paid, he receives the fee in respect of each member, and, as regards attendance on dependent children, he would have to attend these even if the husband only were insured.[1]

As in Germany, there has been a large increase in the cost of medical service. For all the recognised societies the cost per member was 3s. 2d. in 1893; 3s. 10d. in 1900; 4s. 7d. in 1909. The rise has been larger in provincial towns and in rural districts than in the capital towns.

Another manifestation of the rise in the cost of medical service is the amount of the expenditure under that head as compared with the amount paid by the State in subsidy. When the insurance law was introduced it was expected that the subsidy would at least cover the cost of medical service. For some years it was more than sufficient to do so, but since 1898 the cost of medical service has been larger than the subsidy, and the excess cost has been growing larger year by year; in 1909 it was over £22,000 (D).

The increase in the cost of medical service is perturbing to those who have the interests of the working classes at heart. They fear that if the cost goes on rising the stability of the sickness societies will be endangered, or that at least

[1] Special payment for attendance on children may be provided.

they will be gravely impeded in the beneficent work which they are doing. Some go so far as to advocate a State medical service as a way out of the difficulty, among them no less a person than the very able former Government inspector of sickness societies, Dr. Sörensen, now inspector for unemployment insurance. But the general opinion appears to be strongly against such an attempt at solution among sickness societies, doctors, and independent experts, and the suggestion has not come within the range of practical politics.

The reasons for the increase in the cost of medical service are much the same as those in Germany—better service, including more specialist treatment;[1] above all, rise in rate of remuneration, which is partly the consequence of increase in cost, and rise in standard, of living.

In contrast with Germany, the average number of days for which benefit is given does not appear to have risen in Denmark. The following figures show the average number of days a year for which money or institutional benefit was given in recognised societies during certain periods, in the case of (*a*) men, (*b*) women—

Period.	(*a*)	(*b*)
1893–96	6·0	5·2
1897–1900	5·6	5·0
1901–4	5·3	4·6
1905–8	5·2	4·6
1909	5·0	4·5

The steady fall is encouraging though it is difficult to estimate the exact significance of the figures because, as stated, they relate only to persons who have received money benefit or institutional treatment. Money benefit is only paid when the patient is unable to follow his or her employment, and some societies do not pay money benefit to women members, even when they are disabled from work. Still, the figures point to a genuine reduction in the number of days for which benefit is given, a reduction which is mainly attributed to improvement in control.

One of the most favoured means of special control is what is known as the ticket system. It has long been a

[1] But specialist services do not appear to be provided to so large an extent as by the big German societies.

common practice, where the doctor is paid according to services rendered, that members who require a doctor's services shall first obtain a ticket from an official of the society, authorising the attendance of a doctor at the expense of the society. Generally these tickets were granted free of charge. But the practice is increasingly being adopted of charging some small sum for the ticket, from as little as 2d. to over 1s., in a few cases, the amount of the fee in some instances differing according as to whether the doctor is wanted for attendance at the home or not.

This small measure is stated to have been sufficient to reduce the charges by a third in the case of some societies, but probably all that saving should not be attributed to this check, as closer general supervision in other ways was doubtless introduced at the same time. A large number of societies have now adopted this plan. The inspector is strongly in favour of it, and some societies, of which the stability was being threatened by increased medical charges, have been compelled by him to put it into force.

In Denmark, as in Germany and the United Kingdom, the terms of treatment of persons above a certain income is a crucial question. The Danish law provides that only persons whose economic position is similar to that of wage-earning workmen, such as small peasants or tradesmen and the like, can be beneficiary members of sickness societies, that is, members with a right to benefit. It also provides that any complaint made that a person of superior position is a beneficiary member of a registered society may be referred to a committee for investigation, the committee to consist of the doctor of the society, a representative of the society, and a person chosen by the local public authority. The Government inspector of insurance may in any case appeal against the decision of the committee to the Minister of the Interior. The latter's decision is final.

Limits of income and property have been fixed by the Government. The limits differ for Copenhagen and

Frederiksberg, for provincial towns, and for rural districts, being higher for the first than for the second, and for the second than for the third. But these limits do not apply to ordinary industrial workers—there would be comparatively few such persons with incomes or property above the limits fixed—and are restricted to tradesmen, clerks, peasants, and the like. The limits of income are for—

Copenhagen and Frederiksberg—1,800 crowns (£100), with an additional 100 crowns (£5 11s.) for every child at home under 15 years of age.

Provincial towns—1,200 crowns (£66 13s.) to 1,400 crowns, with a similar allowance for children.

Rural districts—800 crowns (£44 9s.) to 1,000 crowns, with a similar allowance for children.

The limit of property is 5,000 crowns (£278 approximately).

The doctors assert that the recognised sickness societies contain many members who are disqualified for membership because they possess income or property above the limits. The inspector of insurance retorts that this is not so, and that, if it be so, the doctors have their remedy close at hand ; they need but make their complaints and these shall be investigated by properly constituted committees.

The doctors reply that this remedy is not one easy to use ; that, if they make complaint, they run the risk of unpopularity, not only with the person against whom complaint is made, but with the sickness societies and with insured persons generally, and are liable to suffer in consequence. But the doctors can scarcely expect others to do the work of protecting their interests. If they do not choose to take the necessary steps they cannot complain if they have to suffer. And they are so well organised that there should not be any difficulty in preventing a doctor who takes legitimate steps to safeguard his interests from being unreasonably penalised.

It is interesting that, whereas in Germany the income limit has been raised, in Denmark the proposal is to make

it more stringent. The sickness insurance law is shortly to be revised. A committee has been considering what amendments are desirable. One of their recommendations is that the income limits shall be applied to industrial workers as well as to other classes.

It is considered also that, apart from the claims of the doctors, the general interests of State and community are involved in securing that persons well able to provide for themselves do not become beneficiary members of sickness insurance. The intention of the law would be defeated if the very liberal public assistance which is given to insurance were appropriated by persons well provided with this world's possessions.

A.—Average Cost per Member per Annum of Payments to Doctors for Medical Treatment

Year.	Societies in				All societies.
	Copenhagen and Frederiksberg.	Provincial towns.	Island rural districts.	Jutland rural districts.	
	s. d.	s. d.	s. d.	s. d.	s. d.
1893	3 3	3 1	2 10	3 5	3 2
1895	3 3	3 3	3 2	4 1	3 4
1900	3 8	3 11	3 8	4 5	3 10
1905	3 11	4 4	4 1	4 10	4 4
1909	4 3	5 1	4 6	4 9	4 7

B.—Increase in the Proportion of the Total Expenditure of Sickness Societies now Spent on Medical Service [1]

Expenditure on	In 1893. Per Cent.	In 1901 to 1906. Per Cent.
Payments to doctors and for conveyance	27·7	35·4
Medical and surgical requirements ...	12·7	12·1
Hospital treatment	5·3	8·7
Money benefit	45·6	36·5
Administration	8·7	7·3
	100	100

[1] In estimating the significance of the increase, account has to be taken of the larger number of persons now insured than formerly, especially of women and of persons of small means.

C.—Percentage of Total Expenditure paid to Doctors for Treatment, Year 1909—

	Per Cent.
By societies in Copenhagen and Frederiksberg ...	22·0
„ „ „ the Provincial towns	33·0
„ „ „ „ Island rural districts	48·0
„ „ „ „ Jutland rural districts	57·0
„ all societies	37·0

D.—Relation between Amount of State Subsidy and Payments to Doctors for Medical Service

(*a*) Amount by which State subsidy exceeded payments for medical service.
(*b*) Amount by which payments for medical service exceeded State subsidy.

Year.	(*a*) £	(*b*) £
1893	4,380	—
1895	1,801	—
1900	—	1,801
1905	—	11,080
1909	—	22,130

The movement has been practically without a break—excess of State subsidy gradually growing less, and finally being replaced, since 1898, by an ever-increasing excess of payments to doctors.

CHAPTER IX

Remuneration of Medical Practitioners

Conclusions

1. *Medical practitioners will demand, and will probably obtain, higher rates of remuneration from the working classes than have been general in the past.*

The most prominent fact that issues from the enquiry into the remuneration of medical practitioners is the rapid rise in recent years. This is manifest both in Germany and in Denmark. What are the reasons?

The societies, or their sponsors, sometimes declare that the rise is due to the unfair pressure of the doctors; that, of late years, the number of doctors has increased more rapidly than the need for them, and that the doctors have demanded larger payments from their patients in order that there may be more money to go round; and that they have been able to make this demand effective because, holding as they do a practical monopoly, strong organisation is easy for them.

Undoubtedly, the doctors have gained much from the strength of their organisations. Without it they would not have been able to secure nearly so much as they have. But to attribute all their success, or the main part of it, to the selfish power of their associations is radically to misinterpret the conditions and to block the way to a wise solution, a solution which can only be won by mutual understanding on the part of societies and doctors.

In dealing with the rise of remuneration in Germany,

I have already entered in detail into some of the reasons therefor—

That the rise is partly nominal, being due to increased cost and higher standard of living;

That patients now resort more freely to doctors, of whom more service is thus required;

That treatment is more elaborate; practitioners are more highly trained and more specialist service is given.

No part of the rise of remuneration attributable to these causes can be regarded as a real rise. The doctor does not receive an absolute increase in the price paid for his service.

But there has undoubtedly been also a real rise. And this rise has been largely due to causes in operation in all industrial countries.

There is no doubt that in the past many classes of persons have been accustomed to receive medical service at less than cost price. There has been a large amount of gratuitous service—at hospitals, dispensaries, etc. But further, ordinary medical service has often been given at a low rate, and the doctor has been able to recoup himself by charging a high rate to his well-to-do patients.

The practitioner is able to play this part of Robin Hood so long as he counts rich and poor among his patients. He can take from one to give to the other. But a feature of modern conditions is the large aggregations of population of a similar social level. Whole districts will consist of only persons with small, sometimes very small, means. The doctor may have to depend on these alone for his income. The Robin Hood in medical service becomes as impossible as the bow and arrow in warfare. The doctor has to obtain a commercial price even from his poorer clients.

Three alternatives are open to the doctor who finds that his patients belong wholly to the working classes, and are therefore not able to afford any but a moderate payment for medical services—

(1) He may charge higher rates.

This, as we have seen, he is effectively doing. The extent to which he can go obviously depends on the amount of the earnings of the workman. That he has to pay more for medical service is one of the goads driving the workman to press for higher wages, a goad small in itself but forming one of a number pushing him in the same direction.

(2) The doctor can purvey a ready skill with rapid repetition to a multitude of clients, and make up in numbers what is lacking in individual payments.

This, too, an occasional practitioner is doing, the shilling or sixpenny, or even more lowly-priced doctor, achieving no doubt some amount of good in his express rush through his patients, but doing also much harm and not giving the thoughtful treatment demanded of effective service.

(3) The standard of living, and correspondingly the standard of remuneration, may be reduced.

Doctors are generally drawn from classes above those of their working-class patients. They have been accustomed to higher standards of living, and expect to be paid for their services at rates adequate for the maintenance of those standards.

It may happen that the working classes will endeavour to secure that they shall be served by persons with standards nearer to their own, persons who will be content with comparatively lower remuneration than that which generally now prevails. Already a few, aided by scholarships, rise from the ranks of the working classes or similar station to become medical practitioners. In their early days they may dream of a Harley Street with its fame and perquisites, but they readily become content with an income which keeps them little above the standard of the best remunerated of their working-class patients.

The key lies in the cost of education, including the

cost of maintenance during education. If either the cost could be materially reduced, or more ready and liberal means be provided of aiding members of working-class families to meet the cost, the way would be open for a large invasion of medical practice by persons with working-class standards.

It will probably occur to most persons that, if such development as that suggested is to take place, it will come through the cheapening of medical education through subsidies from State or local authorities. But it is quite possible that insurance societies of working-men, singly or in combination, may themselves at some future time adopt a policy of facilitating the entrance into the medical profession of persons of their own rank, aiding them by scholarships or other grants. Not only may they be driven to this course by unwillingness or lethargy on the part of public authorities, but they may prefer to take an independent course rather than to lean on the arm of the State, which does not always guide whither they would wish to go.

The general line of development in the direction of opening the medical profession to members of the working classes which has been suggested is by no means a mere fanciful creation. It has already taken place in some sections of the community, in the case of clerks, for example. Still more suggestive is the case of teachers. There, special measures have been taken to bring within the reach of members of the working classes expensive training to befit them to take up the profession, with the result that to-day the teaching needs of the working classes are met largely by members of their own class who have been trained mainly at the public expense.

No doubt any movement towards what may be termed the democratisation of the medical profession has its dangers. There will be obvious risk that efforts towards cheapening the means of training may result in cheapening the training itself.

Medical service may become less efficient. The medical profession also may become overcrowded, with bad results. But, if the dangers are adequately realised, proper precautions may be taken against them. And, on the other hand, the "democratisation" would not be without possible advantages, apart from any result in reducing the price of service to the working classes. The necessity of a sympathetic understanding of the conditions of life of the patient is a cardinal need of good ministration. Its crucial importance is being increasingly recognised in matters medical and other. It is generally more likely to be forthcoming from a person reared in circumstances akin to those of his patient than from one brought up in wholly different conditions. The danger is lest the standard of efficiency in other matters be reduced.

It will be manifest from what has been said that insurance in itself is only a secondary cause of the difficulties which arise with regard to the remuneration of medical practitioners. The primary causes lie deeper. The difficulties are partly one of the far-thrown results of the industrial changes of the time. They issue especially from the aggregation in districts of large populations consisting almost entirely of members of the working classes. The industrial revolution, which has brought political democracy in its train, may bring also "medical democracy." Insurance plays but an incidental part in the process, but nevertheless an important part, for it brings the problem into focus and makes manifest the tendencies which have been working beneath the surface.

2. *Payments by sickness insurance societies or authorities for medical service should be in the form of capitation fees.*

(*a*) Payment according to particular services rendered presents great difficulties.

It is almost impossible for a society or other insurance authority to exercise satisfactory control

directly—to tell, for instance, whether a case has been visited more often than was necessary; whether the patient was visited at home when attendance at the surgery would have been quite practicable without harm to the patient; whether a particular operation was necessary; whether drugs have been prescribed with due regard to economy; whether a patient has been unnecessarily certified as unable to follow his employment. These and similar questions often baffle the expert medical mind: they are generally beyond solution for the layman.

It is of course open to the society to employ a salaried confidential adviser. But this will not solve its difficulties. Expert will confront expert in opposing decision. And societies will probably not be able to afford purchase of experts in the very first rank: they are costly.

For the doctors themselves also there are strong objections. If a society does pay remuneration according to particular services rendered, it cannot forego at least attempting control of details. The control will in large measure be exercised by lay persons, this even when confidential medical advisers are employed. Such control, exercised in technical matters of expert knowledge, cannot but be irksome to the doctors, and provocative of frequent disputes.

When payment by a society is in the form of capitation fees, control by the society is more easily exercised. For it is not necessary to go so much into detail: attention can be concentrated on broad results.

(*b*) Payment by capitation fee is more in accord with modern notions of medical service.

Payment according to services rendered is the form of remuneration appropriate to a stage of thought when illness was regarded as a necessary calamity to be removed or mitigated by a number of more or

less mysterious services rendered by the magician-doctor. But more and more emphasis is being laid on medical service as preventive, and, when curative, not simply curative of symptoms, but fully restorative of complete health. For this view of medical service, capitation payment is the logical form of remuneration.

It is true that, in present sickness society practice, medical service is apt to be concentrated simply on the cure of existing ills, though even in this respect, it should be animated by the larger spirit of securing full restoration to sound health. But it is not difficult to foresee that in the future, as the workman realises more and more the real inwardness of the problem, sickness societies are likely to lay increasing stress on the preventive side of medical work. It is significant that German social democrats are demanding that members of sickness societies shall be periodically examined by their doctor; and, if found to be in need of recuperation, that they shall be given it at the charge of their societies. It does not need any very deep knowledge of human nature to realise the enormous dangers lurking in such a proposal. Its adoption without proper consideration and safeguards would probably be disastrous to a society and the prelude to certain bankruptcy. But fundamentally, the notion is right. The problem is how to carry it out without bringing the building down on one's head, instead of securing the undoubted benefits which it offers.

The history of medical remuneration in Germany clearly points to capitation fees as the form of payment for medical service. Doctors may hanker after remuneration according to services rendered, but in practice they are content with capitation payment, provided that the amount is adequate.

Denmark may seem an exception. There, payment according to services rendered has made headway in recent

years. This has been primarily due to the power of the doctors. The results have not been encouraging. And in the capital towns, almost the only district with very large aggregations of population, capitation payment still prevails.

3. *It is reasonable that individual doctors should be remunerated according to services rendered.*

(*a*) Payment of remuneration on this principle is the only system fair to the individual doctor.

However much emphasis may be laid, and rightly laid, on the preventive side of medical service, what bulks largest in the mind of the doctor, in any individual case, is the amount of work involved, and he very naturally wishes to be remunerated accordingly. Where there is free choice of doctor there may be special reasons for remuneration according to services rendered. The patient who has at one time been treated by a doctor who has given him but patchwork service may, on the occasion of the next illness, go to another doctor, who may have to make up for the shortcomings of his predecessor. If the doctors were paid simply by capitation, or even per case, each would receive a similar amount in respect of the case, although the services of the one might have been worse than useless, those of the other, effective for permanent cure.

(*b*) It is to the interest of the patient that the individual doctor should be remunerated according to services rendered.

Unless he be so paid, the doctor may shirk the necessary work. Cases needing much attention, frequent visits for instance, may not receive the necessary service if the doctor is paid the same amount, whether much or little attention is given.

No doubt doctors can generally be fully trusted. But it is always well that virtue and interest should be on the same side. There is also the check that a

doctor who neglects his patients loses clients. But it is often difficult to tell when there is neglect, especially in expert matters appertaining to a calling like that of the doctor. And some of the qualities in a doctor which catch clients have not much to do with the worth of his services. A pleasing, affable manner often attracts more than skill or even real assiduity.

(*c*) There is also advantage to the society in payment of remuneration to the individual doctor according to his services.

The arguments which have been used in the preceding section could also be used here. It is to the interest of the society not less than that of the patient that the doctor should give the care and attention necessary for effective cure.

And there are other reasons. There is much talk in Germany and in Denmark of hospital abuse. It is said that the doctors of insurance societies send cases to hospitals too freely. And there is undoubtedly some truth in the complaint.

One of the principal reasons given for the mischief is that, under present conditions, doctors often have no incentive to give troublesome and irksome treatment to a patient at his home. When a doctor is paid by capitation, and that payment often wholly inadequate in amount, what wonder, it is said, if he sends a troublesome case to a hospital when he can. It is not simply that he has no encouragement to give treatment which makes heavy demands on his time ; more, he is not paid in a way that enables him to provide himself with the facilities which would make it possible to give special treatment, and to obviate sending a case to the hospital. This latter point of view was very forcibly put to me by a skin specialist in one of the German towns who had provided himself with elaborate electrical apparatus, and who thus

was able to treat at his surgery cases which would otherwise have had to be sent to a hospital. But he was able to give such treatment to insured patients only because, more fortunate than some of his fellows, he received reasonable payment for the treatment.

It does not pay the societies, much less the community, that there should be sent to hospitals cases which, under a judicious system of medical remuneration, could be equally well treated at home. To adopt, on the score of economy, a form of medical remuneration which encourages hospital abuse is to snatch at shillings and to throw away pounds.

The influence on the general attitude of mind of the doctor is also important, an influence subtle and dangerous. If doctors deal with their cases with an accepted axiom at the back of their heads, an axiom perhaps accepted without any very deliberate recognition of it, that troublesome cases should be sent away for institutional treatment, this attitude cannot but adversely affect their practice.

Of course, doctors are subject to revision in sending their cases to hospital, and this induces some care in their recommendations. But it is often very difficult definitely to say that a case should by no means have been sent for hospital treatment, although the general indications may clearly point in that direction.

4. *The combination of capitation payments by the sickness insurance society (or authority) and remuneration according to services rendered to the individual doctor is best secured when the society contracts with a corporation of doctors, making capitation payment to the corporation, and the corporation dividing the proceeds among the several doctors according to their respective services.*

The reader may have thought that he was being led into a contradiction—capitation fees advocated in one place as

against payment according to services ; payment according to services in another place as against capitation fees. But the first was urged from the point of view of the society, the second from the point of view of the doctor. And the present proposition shows how the two may be combined in a harmonious system.

The corporation of doctors serves as a buffer between society and individual doctors. It is not an essential of the system. Thus we saw that in the case of the Hamburg fund for domestic servants there is a somewhat similar system, but the authorities deal directly with the doctors without an intervening body.

But there are advantages in dealing with the doctors as an organised group—

(i) Control is facilitated.

Under such a scheme as that at Hamburg, it is to the interest of each of the participating doctors to see that his fellow practitioner does not overcharge, for the more any one doctor gets the less there is for the others. But the Hamburg scheme does not turn this interest in mutual control into organised machinery for supervision. The question is considered at length in chapter XII.

(ii) The society escapes the sometimes difficult task of deciding how the value of individual services shall be estimated.

In Germany the task is rendered much easier by the existence of State tariffs of medical charges. But these tariffs are not always followed. The doctors may be allowed to decide for themselves how the proceeds shall be divided. This gives the doctors more freedom, and they cannot throw stones at the society for any faults on this score.

Arrangements on the lines indicated have been made at a large number of places in Germany, and that by some of the most important societies, such as those of Leipsic and Munich. So far as indications go, it is only when

arrangements of this kind exist that there is prospect of permanent peace between doctors and societies.

It may be urged that, whatever has happened in Germany, in Denmark there is no indication of a trend in a similar direction. But there are special reasons to account for this. Outside the capital and a few other towns, the country is sparsely populated, and there is therefore the less opportunity and need for such a system. And in Copenhagen and Frederiksberg the practice of employing district medical officers still prevails. It is probable that, if free choice of doctor comes to be established in Copenhagen and Frederiksberg, some system such as that outlined in this section will be adopted.

5. *There are considerable advantages in making the insured person pay for part of the cost of medical service out of his private resources.*

(*a*) The cost of medical service is thereby reduced.

A grave danger of insurance is the abuse of medical service. Persons who are insured are apt to run for the doctor on the smallest pretext, and also to demand his services at inconvenient times. This is so in Germany and in Denmark. The greatly increased resort to the doctor is cited as one of the reasons for the large increase in rates of remuneration, and doctors say that it is unfair to compare average payments made in respect of insured and private clients, because the latter generally claim the services of the doctor rarely and only on serious occasions. It is not simply that insured persons run to the doctor right at the beginning of an illness. That were an advantage in some ways. But they call for his services often when there is no real need for them.

(*b*) Private interest checks a tendency to morbid susceptibility, which is a grave danger inherent in all schemes of insurance against sickness.

Valetudinarianism is a danger which, unless discreet precautions be taken, hangs on the skirts of all insurance against sickness, or invalidity, or accident, a habit of mind ready to fall victim to disease, quick to exaggerate small symptoms to gross proportions, and to make the person ill by mere weight of thought. And who of us in the course of a week is not a victim to some molehill of symptoms which "by taking thought" could readily be magnified to a mountain, or a range of them.

This evil of valetudinarianism needs to be considered at length. In this volume I shall only briefly mention a few matters touching it. There is little doubt, I think, that Germany is suffering from the evil, and that the existence of her insurance schemes has much to do with the condition.

Not that the evil is due solely, perhaps not even primarily, to insurance. Insurance is but one in a number of causes. In recent years men have become more and more alive to the part which mind bears in the causation of disease. Yet, unavoidably, the very efforts to cope with disease may seriously weaken the mental barriers to its inflow. On every hand institutions for dealing with disease are multiplied, insurance schemes among them. And the very fact of doing this emphasises the existence of disease. Each institution serves as a point of suggestion for ailment. The youth who read the medical treatise thought that he had every ill described except housemaid's knee. The ordinary citizen is becoming surrounded by institution after institution for coping with disease. There is danger that they will do for him what the medical treatise did for the youth; and they are always open before him.[1]

The danger is a very serious one, much more serious than deliberate malingering. The poison works more subtly and insidiously. It saps the mental resistance to disease.

[1] The influence of the clever advertising of patent medicines is also very great.

If valetudinarianism to a very large extent were an inevitable consequence of insurance, so grievous would be its results that insurance would probably have to be pronounced a curse, not a blessing. It is very difficult, from the very nature of the evil, to estimate how far it exists. But a careful student of insurance in Germany cannot but be impressed with its existence. In Denmark, for various reasons, it seems to prevail less. But the good results which have been achieved by making the insured person pay some small amount before he can receive treatment, or by making him pay for part of the cost of drugs, &c., go to show that the evil exists there also.

But how does making a man pay for part of medical service help to meet the evil? It adds incentive to resistance to disease, an incentive which counteracts in some measure the influence towards valetudinarianism, and experience shows that the incentive is very effective.

Not that payment from private resources of part of the cost of treatment is sufficient to meet the danger. Further measures are imperative. Reference will be made to some of them later.

(*c*) Part payment from private resources is ultimately in the interest of the insured person himself.

In the interest, that is, of the generality of insured persons. Valetudinarianism not only saps health, it wastes means. The amount which a workman can set aside for insurance is strictly limited. Economy is essential. He cannot afford to have his resources drained by ailments created of his imagination, spent to relieve morbid ills born of valetudinarianism. Insurance under such conditions might be beyond his means. And, still bigger question, it is to his interest to resist with all his powers, to build up the strongest barriers that he can, against any forces which tend to undermine health.

It may be urged that to require a person to pay out of his own resources for part of the cost of insurance is to violate the essential principles of insurance. Further, it deters the sick person from immediately seeking the services of his doctor at the very beginning of an illness, and it is desirable that undue obstacles should not be placed in the way of his doing so.

These are valid objections and deserve careful consideration. But when given all their force, they do not counterbalance the grave risk of abuse, the great difficulties of control, under modern conditions, when medical benefit is provided wholly out of insurance funds. The ideal, and a complete system of insurance is the ideal, has to be framed to meet the limitations of actual conditions.

It is true that the laws of Germany and Denmark in themselves lend little support to such a proposal as that made. In Germany, the law requires that each sickness society shall provide medical service wholly at its own cost. The new law provides that in certain circumstances a society may pay additional money benefit in place of medical service. But this provision is inserted to meet disputes with doctors. Suggestions have been made that a deposit system should be combined with the insurance system, so that part of the benefits paid to an insured person should come out of his own resources. But this has not been adopted nor does there seem to be any noticeable demand for it. German workmen and German thought have been accustomed to a full insurance system, and it would be a drastic change to alter it.[1]

In Denmark also, the law contemplates that generally the sickness societies should provide full medical service. Some societies have availed themselves of the privilege of paying part only of the cost of medical service, and this arrangement seems to be satisfactory. And apart from this,

[1] Even in Germany, the society may pay only part of the cost of some forms of treatment, *e.g.*, treatment at a clinic (see the particulars given in pp. 250 and 254–5 respecting the Leipsic Society).

in two directions Denmark has made an approach towards a partial deposit system—

(i) in making a small charge to a person before he (or she) can obtain the services of the doctor at the expense of the society—the ticket system ;

(ii) a large number of societies do not pay for the cost of medical and surgical requirements or pay for part only of the cost : this matter is considered in chapter XIV.

It has to be recognised that workmen might not be very well disposed to such a system. They might resent having to pay for part of the cost of medical benefit out of their own pockets. Most of them are without practical experience, and not being conversant with the intricacies of the problem, they do not realise the difficulties which arise or the dangers which lurk in an insurance scheme. And on this account practical reasons may make it expedient to concede a full insurance system, and to trust to experience to work out a solution in accord with real needs.

The problem is largely one of solidarity of feeling in the insurance group and of means of control. If the group is small, as in the case of some lodges of friendly societies, the difficulties may be overcome with moderate ease. And in the future, when workmen have become more accustomed to act in co-operative concert, to stand shoulder to shoulder for common ends, a spirit may be developed in the ordinary workman which will make progress in the direction of complete insurance easier. But for the present it is to be feared that this spirit, richly though it exists in large numbers of workmen, is not generally distributed in sufficient strength to make it wise to forego the gain of appealing to strictly selfish interests by combining a deposit with the insurance system. A small measure of the deposit system would probably prove sufficient leaven, and it is desirable to keep it small.

6. *Systematic provision should be made for educating the insured public as to medical treatment and in matters of health.*

(*a*) This is necessary for checking valetudinarianism.

It is not enough, as was stated in the last section, simply to rely on the play of self-interest. The evil works subconsciously. The mind becomes permeated with a susceptibility to disease. How is this to be counteracted? Recognise the existence of the evil and take deliberate steps to counteract it. The subconscious influence of insurance schemes and of other means of attacking disease must be met by deliberate education in the contrary direction. The public must be taught to realise the danger and to take proper measures against it.

(*b*) The results of insurance should be made the basis of active propaganda for health.

A mere negative policy will not accomplish much. It is necessary to drive home active measures for preventing disease and, still more important, for attaining higher standards of health.

A comprehensive scheme of insurance affords unrivalled opportunities of collecting information as to the incidence and causes of disease. If full use is not taken of this opportunity, one of the chief gains to be derived from insurance is cast away. The various insurance authorities should extract to the full the lessons of insurance experience and, by active, steady propaganda, should plant them in the minds of the insured, so that the latter may not only advocate and support the public measures which may be desirable, but, even more important, should adopt those personal habits which conduce to a high standard of health.

In this work of education it is necessary to distinguish two functions.—

(i) Extraction of information.

This is expert work. Records should be kept by the various societies and authorities which will facilitate the work. The records may cost a little trouble and money to keep, and societies,

not realising the great gains to be won in the long run, may be unwilling to keep them, but the importance of proper records is pre-eminent.

For the full analysis of these records special provision will probably have to be made. If societies can be persuaded to keep good records that is likely to be as much as can generally be won, for some time at least. The extraction of the lessons to be drawn from the records, the proper consideration of the results—that is a task which costs money, money which, as already stated, will bring a rich return, but a return which matures slowly and often not very perceptibly, though not the less surely. But the workman wants quick and manifest returns. He is not apt to take long views, except instinctively, and it is not possible to count on his instinct in this matter.

The work is particularly suited for the central authority. Properly qualified experts can be employed. Further, the central authority will have a large range of material on which to draw. It can extract its experience from a large number of bodies, not from one only.

One of the defects of German sickness insurance has been the lack of any proper central authority. For invalidity insurance there is such an authority which in some measure co-ordinates the work of all the local authorities, but there is not a similar body for sickness insurance. Consequently there has not been any proper attempt to extract the valuable lessons of the experience of the thousands of insurance societies. This defect will be remedied under the new law.

The need of sifting the records has been strongly felt, and has been given practical effect. In 1903 the *Reichstag* voted £16,250 in order

that the records of the Leipsic district sickness society should be analysed by experts, under the direction of the Imperial Statistical Office. The Leipsic society was selected because it has exceptionally good records. The work has been recently completed. It took seven years. Very interesting and valuable results have been obtained. Many of the German sickness societies issue very full and excellent annual reports.

In Denmark, there is a central sickness insurance authority. The work of the authority has hitherto lain mainly in matters of administration, and possible legislative changes have greatly occupied its attention. But there is little doubt that in time it will actively take up the work of analysing insurance experience.

(ii) Propaganda.

Two kinds of propaganda work may be distinguished, that which aims at obtaining action by public authorities and that which aims at obtaining action by individual persons. For the former, it is less propaganda than scientifically accumulated data that may seem to be required. But public measures depend in a democratic country, and rightly depend, on public support. So that even for them, propaganda applied to individuals is necessary.

Propaganda is best carried on among persons by the societies and by individuals closely in touch with them. Not the central authority therefore, but the societies, are the proper media for such work. The central authority should work through them. And, as we have already seen, this is one of the reasons why it is desirable not to deprive societies of the administration of medical or other benefit. They should receive and realise the concentrated force of sickness claims in order that

they may be thus induced to make the more strenuous efforts towards amelioration. The central authority should take care that they are kept fully informed of all the latest results of research, and should also bring discreet pressure to bear to ensure that the societies are taking active measures to educate their members accordingly. In this way, by intelligent co-operation and steady pressure, much should be accomplished.

As to the means by which the propaganda is to be carried out, that will depend largely on local circumstances. Lectures and leaflets and pamphlets will be useful, though their value is often over-estimated. Vivid exhibitions, going from town to town and from village to village, will be found effective aids. In Germany, and especially in the wide-awake United States, very much has been done in this direction in recent years. And in our own country also the value of such exhibitions has been appreciated in practical fashion. There is no reason why they should be restricted to tuberculosis. They can and should be extended to other matters.

Very effective work may be done by the visitors employed by societies to look up members in receipt of sickness benefit. They may be used, not only for verifying that the patient is really unable to follow his employment and is conforming to the directions of the doctor, but also as apostles of hygiene. Coming into close touch with the patient at susceptible moments, they have splendid opportunities for inculcating valuable lessons, lessons that will not only aid present cure, but will foster future health. Some of the German societies lay stress on this side of their work.

> Probably more important than all these things will be the general atmosphere of thoughtfulness which will be disseminated among the members of a society of which the officials and members are quick to learn and keen to instruct. By informal converse, by force of example, new ideas and new habits may be inculcated in a way much more effective than by any set scheme of instruction. It is the general attitude of mind that counts.

It will at once be manifest that the work of the insurance authorities and societies under this head impinges on that of the authorities for public health. What are the relations between the two groups? The question is important, and is considered in a separate chapter (XIX).

7. *The claim of the doctors that a distinction should be drawn between the terms on which medical service is rendered to persons with comparatively large earnings, and persons with small earnings, merits sympathetic consideration.*

It is very striking that in Germany and in Denmark, and elsewhere, the fixing of an income limit for persons entitled to be insured for medical service on ordinary terms is a crucial question. It is pressed with an unity of demand and a firmness of organisation which may well make the industrial workman envious. Rightly or wrongly, the doctors appear to regard the matter as vital to their interests. This far-flung, hotly-waged agitation must have its roots in some deep-lying causes.

First, the doctor's point of view. The agitation is, of course, largely a cupboard campaign, a matter of remuneration. The doctors think that they will get less from the well-remunerated artisan, foreman, and clerk as an insured than as an uninsured patient. If these are members of an insurance group which includes large numbers of lowly remunerated workers, and all receive medical service on the same terms, the doctors fear that they will suffer, that the

rates paid for medical service will be determined by the ability to pay of the lowly remunerated members rather than by that of the others. In Germany, doctors feel that they have the additional grievance that contributions are not levied on more than 6s. a day of earnings and must not exceed certain percentages.

Against these contentions of the doctors it is urged that the very inclusion in one insurance group of the lowly and the well remunerated tends to increase the rate of payment made in respect of the former. The contributions from employer and public authority likewise add to the amount which can be paid. Further, under an insurance scheme, the doctor is certain of his payment, whereas in private practice he often has to go empty-handed, not only from poor patients but sometimes from others also. The German societies in their arguments with the doctors lay stress on this. Without insurance, moreover, many persons receive free treatment, or treatment at much reduced rates, who are brought within the net of a wide insurance and yield their tribute to the doctor.

Clearly these arguments are not without weight, though the doctors may discreetly minimise them. But they will not satisfy the doctors, nor do they seem fully to meet their case. For it has to be remembered that the doctors are contending, not simply for the maintenance of the rates of payment from their working-class patients, but for an increase. Like Oliver, they want more, and, as we have seen, not without reason. They urge that treatment is becoming more elaborate. They contend that, under insurance, work will be heavier; they hear the night bell clanging oftener. And in addition there are broad social reasons, to which reference was made in the beginning of the chapter, why they press for increased pay.

The supporters of the German sickness insurance societies, it will be remembered, during the consideration of the new insurance law contended that allowance should be made for the large rise in cost of living in recent years and that, if £100 per annum was a reasonable

limit in 1883, a much higher figure should be fixed now. This is simply a question of where the limit should be placed, a question to be determined according to the economic circumstances and prevailing medical practice of each country. As a matter of fact, the German societies would like the limit placed much higher than the figure which would correspond with £100 in 1883. It has to be borne in mind also that in Germany the limit does not apply to ordinary industrial workers. There is, of course, less need of its application in that class since relatively few workers would pass beyond it.

The plea of the doctors is not wholly based on remuneration. Behind it lies also to some extent the dignity of their profession. They fear that with low pay will go scurried work, that they will become mere tongue and bottle drudges, treaters of symptoms hurrying through a round of mechanical routine instead of trained experts thoughtfully weighing delicate indications and applying remedies with skilful knowledge which will attack ailments at their source.

The case for one uniform payment for medical service is not free from all question even from the point of view of the insured. As stated, if the lowly and the well remunerated are joined together in one common liability, the former will probably have to pay more for medical service. This would scarcely be fair to them. They would have to pay for association with their more highly placed fellows—and generally, unlike some of their betters, they are not willing to pay a price for the privilege. It has been the practice in the past to charge for medical services partly according to the economic position of the patient, and it is well to recognise conventions of this kind. They cannot advantageously be changed except by changing also the general conditions in which they have their origin.

Nor will it necessarily pay the well-remunerated artisan or clerk or foreman in the long run to get his doctoring at less than what for him is a reasonable price. Things have

a crude tendency to equalise themselves. If workmen receive services below cost, there is a danger that they in turn will have to give their services below cost. But what they should aim for is greater independence ; not that they should drop to the level of the labourer, but that he should climb to theirs, and they climb still higher. And there is the further risk, if a group of persons receives insurance on exceptionally easy terms, that dependence will carry restriction and that, in some way or other, an inroad may be made on the self-government of the group in matters of insurance.

From the point of view of the community in general, it is obviously desirable that doctors should be adequately paid. Adequate payment is a condition of efficient service, and speedy and permanent cure of ailing members of the community can only thus be obtained. On the other hand, however, it is desirable that the terms of medical service should not be so onerous as to make insurance difficult for workmen, for the lower ranks especially. It is in their case that the mutual support and security of insurance is most needed. It is with them that, failing insurance, there is the greatest difficulty in obtaining proper service, and that the community, in default of independent provision, has most often to step in to supply what is needed. A solution of the problem may seem to lie in the suggestion that workmen and employees should organise in different insurance groups, according to their economic position, with different terms of medical service. Apart from its practical difficulties, which would not be slight, such a solution is to be deprecated on social grounds. It would be achieving the desired end by a maximum of disturbance. It would be like setting up sons in different households because it was desired to make a small distinction between them. More intercourse, not less, is needed between the different groups of workers, soft-handed and hard-handed. Where they have common ends it is desirable that they should pursue them in common organisation without the break

of economic position, unless this is unavoidable. They can thus learn from, and understand, each other.

A way out of the difficulty would be afforded if the insured were required to pay for part of the cost of medical service out of their own pockets. It could then be arranged that, while the society paid the basic (and much the larger) amount, additional sums should be paid by the individual members for any services received, the additional sums to be at rates agreed upon between the societies (or their federation) and the doctors' organisation, and to be different according to the economic position of the insured person. Such a system has the virtue of recognising existing conventions while offering no bar to their being superseded if their retention is no longer desirable.

If such a system were adopted, the main difficulties, apart from the fixing of the grades and of the terms of service, would arise in deciding to what class each member belonged. This should not be an overwhelming obstacle. In self-governing groups of workmen it would probably not be difficult to place men with rough and adequate accuracy according to their earnings. Workmen know each other's earnings fairly well. The necessity of dividing members into economic grades would add to the cost of administration, but the additional expenses should not be heavy.

Since the placing of a member would be mainly a matter for the doctors and the societies, it would be best done by a committee representing each side. The list could be periodically revised so as to avoid any question arising when a member was actually in receipt of medical benefit. The periodical revision would provide for permanent change in economic position. As to the weekly variations of earnings which take place in the case of many workmen, the latter could be graded according to their general position.

Disputes would of course arise, though they would be reduced to a minimum by bringing into play a joint committee of representatives of the doctors and the societies. An arbitration committee would need to be

established to which matters in dispute which could not otherwise be settled could be referred. If each side approached the problem with honest intention and goodwill there should not be many difficulties, while the very consideration of such questions by joint committees with representatives from each side would tend to increase that habit of co-operation, that understanding of each other's views and sympathy with each other's requirements which are essential to the success of insurance, whatever the system adopted.

CHAPTER X

Control of Medical Service

GERMANY

The difficulties of adequate control of medical service increase with the freedom allowed to members in the choice of the doctor by whom they will be attended. Where a society employs but few doctors, especially when it employs only one doctor for each district, control is the easier because the doctor is under constant liability to lose his appointment if he does not render service satisfactory to his employer. But when there are in the service of a society a large number of doctors among whom the insured person has free choice, it is not so easy to control by the fear of dismissal. The doctors are not so amenable to the wishes of the society. They take a bolder line of their own. And it is very much easier to control the doings of one man than of many.

Besides, and this may be more important than any other factor, the doctor who has a monopoly of society practice within his district more readily acquires the habit of looking at things from the point of view of the needs and interests of the society than if he is but one of a number of doctors whose employment depends more on the choice of the patient than on the society.

Uniformity of practice, which, within reasonable limits, is so desirable, is difficult to obtain when many doctors are employed. Some doctors will give certificates of inability to work with much more freedom than others. Some will be lax in prescribing, and will not always keep close to economy. Some may pay numerous and unnecessary visits

and so run up expenses. In these matters, and in others, stringent control may be an essential of solvency to sickness societies.

The diversity of practice which prevails in Germany with regard to choice and remuneration of doctors extends equally to methods of control. As will be obvious from what has been written, the form of control depends largely on the extent to which choice of doctor is allowed. I will confine my comments mainly to societies in which free choice, or practically free choice, is granted, for these societies provide the most suggestive material.

In the matter of control as in many others, the Leipsic sickness society is among the most instructive in Germany. As already stated, the members of the society have free choice of doctor and the doctors are represented by a committee through which remuneration is distributed.

It is through this committee also that control over the doctors is mainly exercised. The committee is responsible to the society for the supervision of the doctors, and the society exercises its control through the committee. If, for instance, the society has a complaint to make against a doctor, it makes its complaint to the committee, and it is the duty of the committee to take such disciplinary action as may be necessary if it finds that the complaint is well founded.

The committee among other duties—

examines the accounts of the doctors to ascertain that their charges are right and proper ;

examines their prescriptions to verify that articles have not been ordered which are not allowed at the cost of the society, or expensive drugs when cheaper drugs would have done equally well. If there has been want of care, a sum may be deducted from the remuneration of the doctor as a penalty to be paid over to the society ;

checks the extent to which doctors have certified persons as unable to work. If the committee finds that there has

been serious laxity, it may fine the erring doctor and require him to pay an indemnity to the society, which has been mulcted by having to pay money benefit on the improper certificate.[1]

Arrangements similar to those at Leipsic prevail in other places, with local variations. Thus the agreement between the Munich society and the local doctors[2] provides for separate committees of doctors to control—

(*a*) The charges of doctors.

Some operations for which special payments are made may only be performed, in ordinary circumstances, at the expense of the society with the express consent of this committee.

(*b*) The prescriptions of doctors.

(*c*) The certifying of patients as unable to follow their employment.

But even when the freest use is made of committees of the organised doctors for the exercise of control, a society generally does not rely solely on the committees. It needs to be advised and aided by experts standing in a special relation of trust to it. Hence the employment of confidential medical advisers.

The employment of such officials is common. Thus there are two[3] in the service of the Leipsic society, and in 1910, £760 was paid in respect of their services. The duties of the officials differ at different places (A). They may include—

examination of patients suspected of malingering ;

examination of patients when there is doubt whether they should be sent to hospitals ;

examination of patients for whom special treatment is recommended, such as—treatment in a special institution or a stay in a convalescent home ; a special operation ; a special appliance ; &c. ;

[1] For fuller particulars, see appendix V.
[2] See appendix VI.
[3] Now three.

checking, or assisting in the checking of, the prescriptions of doctors ;

medical examination of applicants for voluntary membership.

It will be seen that some of these duties are similar to those performed at some places by committees of doctors. The division of work between such committees and confidential medical advisers varies. In some cases, it is provided that the committee only comes into play in case of disagreement between the treating doctor and the confidential medical adviser.[1]

At Crefeld, examination of doubtful cases of inability to work is undertaken by two representatives of the doctors (D). A committee is chosen in such a way as to give both doctors and society a voice in its composition. The former choose eight of their number. Of these eight, the societies —or rather the committee of the federation of societies : it is by the federation that the arrangements are made on behalf of the societies—choose four, and these four form the committee of control. Cases are examined by two of the four doctors sitting together at a time.

The experience of the district societies of Düsseldorf has been interesting as regards medical control. The societies give free choice of doctor, and it was formerly arranged that control should be exercised primarily through a committee of the doctors. But this was not found satisfactory. The members of the committee were only chosen for short periods. Apparently there was not much willingness to serve, for the duties were onerous, and, since they involved the checking of fellow-practitioners, not altogether pleasant. There was a want of uniformity and continuity of practice. And a frequently changing committee, drawn from the group of persons to be controlled, has special difficulties in exercising authority.

The result was that the district societies, acting through their federation, decided to appoint a confidential medical adviser. They had to proceed warily, for it was important not to alienate the doctors. It was necessary that the

[1] Cases may be referred to a medical arbitrator when there is difference of opinion (see, *e.g.*, p. 267).

adviser should devote only part of his time to the work of the societies. The doctors were asked themselves to suggest who should be chosen. They recommended a local doctor of high standing, and he was appointed. The societies are very pleased with the working of the new arrangement.

Particulars are given at the close of the chapter of the work done by the confidential medical advisers of some societies in the year 1910 (A). Especially instructive is the information respecting the examination of patients referred to the confidential medical advisers because there was doubt whether they could justly be considered as unable to follow their employment. The large proportion of patients who either declared off the funds rather than be examined, or who, on examination, were pronounced to be able to resume work at once or within a very short time affords striking testimony to the crucial need of control.

The discreet use of the services of a confidental adviser is important to a society not only for preventing particular cases from being improperly a charge on the funds, but, not less important, because—

(*a*) it automatically tends to impose some uniformity of practice among the practitioners as to what constitutes inability to follow employment, and this uniformity is necessary not only to prevent abuses and unfair patronage of the lax doctors, but to prevent feelings of injustice ;

(*b*) it induces the doctor inclined to laxity to adopt a stricter standard, since he knows that he is liable to have his proceedings checked by the confidential adviser.

And the official is an aid to the conscientious doctor. Border-line cases occur in which the latter would be unwilling, on his own responsibility, to declare a patient able to work, but, fortified by the opinion of the confidential adviser, he need not hesitate to do so. This second medical opinion must be available without extra cost to the treating doctor, otherwise he will be backward in making use of it.

But the thread of life is a tangled skein. A close system of supervision and assistance is itself not free from danger. It may weaken the sense of responsibility of the practising doctor, making him throw on the supervising authority duties which he himself should perform. Thus one of the large sickness societies of Düsseldorf mentions in one of its reports that in 70 per cent. of the cases referred to the supervisory committee of doctors, the committee had pronounced the patient able to work within the end of the week in which the examination was made, and contends that, under the system of free choice, the doctors, instead of themselves declaring the patients able to work, cast the onus of this decision on the society and the supervising committee. Clearly if doctors adopted such a practice to any considerable extent the additional charge on the funds of a society would be heavy, if only because of the time wasted before the society or committee could effectively intervene.

Societies generally make special rules with regard to malingering. Thus, in the instructions issued by the district sickness society of Kiel to their doctors the latter are recommended, when malingering is suspected, to curtail the liberty of the patient as much as possible. "Malingering . . . will be the most easily prevented if the pleasure of drawing money carries with it the discomfort of continuously lying in bed."

During the dispute between sickness societies and doctors at Cologne, when the doctors were in the ascendant the societies complained bitterly that they were practically unable to exercise any control over the giving of certificates of inability to work by the doctors. They suggested—

1. that a supervisory committee of confidential medical advisers should be appointed, to consist of three doctors chosen by the sickness societies from a list of doctors submitted by the doctors' association, two of the doctors always to act together ;
2. that the advisers should act under a committee consisting of representatives of the sickness societies and of

the doctors; and that if this committee failed to agree on any matter, another meeting should be held under an independent chairman for the settlement of the question at issue;

3. that the confidential advisers should cease to be members of the local doctors' association, and should not engage in practice for the treatment of insured persons;
4. that the confidential medical advisers be paid by salary, and that £600 should be annually deducted from the remuneration payable for the medical treatment of members towards payment for the services of the confidential advisers.

The scheme further provided that if the doctor treating a patient did not agree with the decision of the confidential advisers respecting a case—

(*a*) he was to confer with the advisers;

(*b*) if there was still disagreement, the patient could be examined by a medical referee appointed for such cases by agreement between the sickness societies (or their federation) and the doctors' association, the decision of the referee to be final.

(*c*) A patient himself was to be given the right to appeal in a similar manner to a referee, provided his society gave its consent.

The scheme on the whole seems well devised, but the relations between societies and doctors at Cologne were too strained for amicable arrangement.

While the societies which have made arrangements such as those described rely largely for control on the organisations of the doctors, at the same time they themselves exercise strict supervision, though that supervision, in details, is effected through the doctors' organisations. For supervision it is of cardinal importance that the society should know exactly what each doctor does, and should have the information in such a form as to make comparison easy and to ascertain, by comparing the records of different doctors, whether any of them appear to be guilty of laxity.

For this purpose it is necessary to know, among other things, what is the record of each doctor as regards—

the giving of prescriptions, including the cost of the medical and surgical requirements ordered;

the giving of certificates of inability to work;

cases revised by the confidential medical adviser, and whether the opinion of the treating doctor has been confirmed or controverted;

the sending of patients to hospitals, convalescent homes, &c., or for special treatment.

Records of these matters, reduced to a form which will make comparison easy, should readily show where inquiry may be desirable.

As an interesting type of such a record, I give particulars, at the close of the chapter, of the information furnished by the district society of Königsberg respecting each of its doctors (B). It will be seen that these ample details should serve as most useful adjuncts of control. They are undoubtedly numerous, but probably well repay the trouble and cost of preparing them.

Arrangements made between societies and doctors would obviously be incomplete without provision for settling matters of common policy and for settling disputes. Between the two groups—sickness societies on the one hand, doctors on the other—there is constant danger of misunderstanding and disagreement. Often they look at things from different points of view. It is necessary that each side should be educated to the other's ideas and a reasonable line of policy hammered out. It will be remembered that at Frankfort it is provided that, before a doctor starts insurance practice, he shall attend meetings of the committees which settle questions with regard to medical service, in order that he may appreciate the needs of his new position. This is an admirable provision. But it needs to be supplemented, as it is at Frankfort and other places, by systematic provision whereby societies and doctors may discuss their common interests.

The Leipsic sickness society has an admirable system, and it will be convenient to give brief particulars of it here to complete the picture of the medical arrangements of this the premier society of Germany. The agreement made between the society and the two district medical associations provides for the establishment of (*a*) a conciliation committee and (*b*) an arbitration committee, in addition to the representative committee to which reference has been previously made.

(*a*) Conciliation Committee—

This consists of three representatives of the society and three of the doctors. It discusses matters of common interest and settles disputes.

(*b*) Arbitration Committee—

This also consists of three representatives of the society and three of the doctors (the chairmen of the two medical associations and the chairman of the representative committee of the society doctors) and, in addition, three officials of the *Kreishauptmannschaft*[1] (local officials; but appointed by the State Government), one being the medical councillor. One of the officials is the chairman. This committee is the final court of appeal for all disputes. Further, should either side give notice to terminate the agreement, it is provided that the matter shall be referred to the committee for its opinion.

This system at Leipzic works satisfactorily.

Similar arrangements exist at many other places. At Frankfort[2] the arbitration committee consists of equal representatives of each side, just like the conciliation committee, but with different members. If a matter cannot be settled by the arbitration committee, it is referred to an umpire chosen by the two sides, or, failing agreement, by lot.

In Würtemberg also, there is very good machinery for settling disputes. The kingdom is divided into five dis-

[1] Saxony is divided into a number of *Kreishauptmannschaften* (not to be confused with the Prussian *Kreiae*), and these are again divided into *Amtshauptmannschaften*.

[2] See appendix VII.

tricts. For each district a committee is appointed for the settlement of disputes, the committee consisting of equal representatives of sickness societies and of doctors, with a Government official as impartial chairman. A committee constituted on similar lines is appointed for the whole country to settle important matters referred to it.

It was originally intended that the new insurance law should contain provision for the settlement of disputes on lines somewhat similar to those which have been described. Various attempts were made to frame arrangements acceptable to all sides, but without success. Among other attempts was a report by a special committee of the Reichstag which recommended that the law should provide for the establishment of local committees, containing equal representatives of sickness societies and of doctors, and, in the case of the more important arbitration committees, also impartial Government officials, for the settlement of disputes. The doctors were not prepared to acquiesce in such arrangements unless the law definitely recognised free choice of doctor as the normal system. They also raised other objections to the proposals of the committee and alleged that, if carried out, they would prejudice freedom of combination, a right which experience has taught the German doctor, no less than the workman, to rate at a high value.

As for the sickness societies, the general attitude among the persons responsible for their management is that they are prepared to acquiesce in the provision of means for settling disputes, but only on condition that the means are such as will not restrict their power to determine for themselves what kind of arrangements they shall make, within reasonable limits, for medical service, and that they are not such as will enable doctors to dictate terms.

In the absence of legal provision for conciliation, it is left to societies and doctors, as in the past, to make their own arrangements for peaceful negotiations. For the moment, owing to the new bitterness arising from the

inclusion in the compulsory insurance of persons with higher incomes than formerly,[1] the advance of conciliation may be stayed. But there is every reason to suppose that, when matters settle down again to their normal condition, the big steps which have already been taken in so many places in Germany towards systematic arrangements for common discussion and settlement of disputes will be continued.

A.—Confidential Medical Advisers

(1) *Leipsic District Sickness Society*

The following are particulars of the work of the two confidential medical advisers of the society in 1910—

8,497 requests were made for visits to patients to ascertain whether they were genuinely unable to work.
- 3,382 of the requests were made by treating doctors.
- 2,494 „ „ „ the head office of the society.
- 2,399 „ „ „ the supervisors.
- 222 „ „ „ the visitors.

Of the 8,497 patients—
- 111 were excused.
- 1,259 did not come for examination.
- 1,300 notified recovery before examination.

As regards the 5,827 examinations made,
- 47 per cent. of the patients were declared able to work forthwith.
- 12 „ „ „ „ „ „ at the end of the week.
- 10 „ „ „ „ to be re-examined at end of 1 or 2 weeks.
- 31 „ „ „ „ declared unable to work.

4,218 cases were reported for visiting to decide whether the patient should be sent to a cure establishment or a convalescent home, or for a stay in the country.
- 582 patients did not appear for examination.
- 3,636 patients were examined.

625 cases were reported for examination as to whether special medical or surgical requirements should be given.
- 108 patients did not appear for examination.
- 517 patients were examined.

1,735 persons were examined who applied for voluntary membership of the society.

---

[1] The sickness societies allege that the doctors' association is only using this as a pretext for pressing their claims, and that the change in income-limit will not really make much difference.

(2) *Königsberg (Gemeinsame) District Society*

Work of the Confidential Medical Adviser in 1910 and in 1909: the figures of the latter year are those in brackets.

The total number of members returned as ill and unable to work during the years were 11,387 (12,485). The society gives free choice of doctor. The average membership was 23,200 (22,400).

2,302 (2,635) patients were examined.

2,117 (2,410) of these were examined at the request of the society.
153 (191) at the request of the treating doctor.
32 (15) „ „ „ patient, who considered that he had been wrongly certified as able to work.

841 (828) were certified as able to work forthwith.
498 (545) as able to work in from 3 to 8 days.
527 (619) as unable to work.
81 (80) were sent to hospital for observation.
355 (544) were certified as able to work by the treating doctor after it was decided that they should be examined by the confidential medical adviser, and did not come up for examination by the latter.

In 36 (19) cases examined, the giving of nourishment, teeth-filling, or the provision of maintenance out in the country was recommended.

(3) *Kiel District Sickness Society*

In the report of the society for 1910, the following particulars are given respecting work done by the Confidential Medical Adviser of the society—

"1,415 patients were reported to the Confidential Medical Adviser for examination. Of these, 480 declared themselves no longer unable to work before examination was made. 346 were declared able to work immediately, and 361 others within 1 to 5 days. 136 were sent to a hospital, and in 83 cases inability to work was confirmed. In 9 cases the medical examination was repeated. Out of every 100 patients who were unable to work, 10 were brought to the notice of the Confidential Medical Adviser, of whom only from 6 to 7 came up for examination."

The society had about 21,000 members and employed 37 medical practitioners.

B.—Königsberg (Gemeinsame) District Sickness Society. Particulars are given in the Annual Report of the Record of each Doctor as regards—

1. Drugs, &c.
2. Wine and brandy.
3. Milk.
4. Spectacles, trusses, and appliances.
5. Baths, massage, cupping, &c.
6. Total of items 1 to 5.

Particulars are given in each of these groups of—
(*a*) Number of prescriptions.
(*b*) Cost of the prescriptions.
(*c*) Average cost per prescription.

7. Number of cases treated.
8. Prescriptions per case.
9. Cost of prescriptions per case.
10. Number of cases certified as unable to work.

11. Percentage of number in group 10 of number in group 7.
12. Number of days of sickness—total.
13. „ „ „ —per case.
14. Number of cases sent for institutional treatment.
Cases sent for dental treatment—
15. —total.
16. —cost of treatment—total.
17. „ „ —per case.
Number of cases referred to confidential medical adviser—
18. —at request of treating doctor.
19. —at request of patient.
20. —by society.
21. —total.
Result of examination by the confidential medical adviser—
22. —certified as able to work immediately.
23. „ „ „ in a few days.
24. —reported as able to work before examination.
25. —certified as unable to work.
26. —sent to hospital.
27. Total remuneration of the doctor.

C.—Extracts from a Publication of the Munich District Sickness Society relating to Control of Patients.

". . . . If the doctor has any doubt whether a patient is unable to follow his employment, the doctor has forthwith to furnish particulars to the society—to the control department—in the form prescribed for the time being. The doctor has to do likewise if he learns that the conduct or dwelling of the patient is not conducive to health.

"In general, the conduct of patients certified by the doctors as unable to work shall be supervised by the controllers appointed by the society, with a chief controller over them. . . . These reports (daily reports of the controllers) shall be made in the presence of a representative of the control committee of the Doctor's Section for Free Choice of Doctor, a medical representative of the society (confidential medical adviser), and the chief controller.

"This committee (committee for preliminary control) shall decide the cases after hearing the controllers and with due regard to the circumstances of each case. The decisions shall appertain especially to the sending of cases to hospitals or in referring them for enquiry to the control committee. In the latter case, the doctor treating the patient shall be informed of the decision, and shall be allowed to take part in the enquiry, and shall be acquainted with the final decision.

"The control committee shall be composed of—

(*a*) Two members (doctors) of the Section for the Free Choice of Doctor, chosen and directed by the Section;

(*b*) the Confidential Medical Adviser of the society, who shall be the chairman.

"The committee shall enquire into cases referred to it by the committee for preliminary control, or, in special cases, referred direct by the society or by any of the society doctors; and shall decide—whether the person is able or unable to work; whether he shall be sent to a hospital or other institution (including a convalescent home); whether he shall be placed under special treatment; and lastly whether

the treatment hitherto received shall be continued. . . . All the members of the Section for the Free Choice of Doctor are required to comply with the decisions of the committee."

The duties of the committee for preliminary control are of wider range than appears from the foregoing, for it is stated later—

"The preliminary control committee has to decide—

what patients have to be referred to the control committee for enquiry;

who shall be sent to hospitals, &c.;

who shall receive special treatment;

who shall continue to receive the same treatment as heretofore."

It is also provided that the control committee "shall meet daily between 10 and 12 a.m., and, if necessary, also between 4 and 6 p.m. . . ."

D.—Crefeld: Medical Arrangements

The arrangements which have been made between the sickness societies and the doctors for purposes of control have worked satisfactorily, and have received commendation from the societies themselves. The following are brief particulars of the arrangements.

Two committees of doctors are appointed—

1. "The Sickness Society Committee."

   This committee—

   (i) examines the prescriptions of doctors to see that only what is reasonable is ordered;

   (ii) scrutinizes particulars of the treatment of patients to ascertain whether the doctor is doing anything injurious to the society or to his fellow-practitioners.

2. "The Confidential Committee."

   This is composed of the four doctors chosen in the manner previously described (p. 110). The doctors act two at a time. The principal work of the committee appears to be the examination of such of the patients certified as being unable to follow their employment—and therefore in receipt of money-benefit—as are referred to it by the society because some doubt exists as to whether there are adequate grounds for certifying inability to follow employment. It is stated that from 60 to 66 per cent. of such cases referred to the committee have on examination been declared not to be such as to warrant the continued payment of money-benefit.

   Systems similar to that at Crefeld have been adopted at a number of places. Doctors emphatically declare that with such arrangements there is little danger that societies will be penalised by too complaisant giving of certificates by lax doctors.

CHAPTER XI

Control of Medical Service

DENMARK

Denmark affords less material than Germany on the control of medical service, not only because the country is so much smaller, but also because, for other reasons, the problem to be met is less difficult. There are two primary reasons which account for this.

1. Most of the societies are small.

   Many of them are very small, as will be seen from the particulars furnished in chapter II, p. 11. The small size of a society facilitates control. The managers of the society and the members generally can the more readily know what the doctors are doing. They are better acquainted with each other, with their faults and weaknesses. And it is also less easy for a member inclined to malpractices, or who indulges in a low standard of conscience in making claims for benefit, to hide his shortcomings from the sharp eyes of managers or fellow-members.

2. In Copenhagen and Frederiksberg, practically the only places where there are very large societies, the practice of employing district medical officers facilitates control. Not only is it easier for the societies to ascertain what the doctors are doing, and to bring pressure to bear on them, but, as previously mentioned, the doctors themselves tend more readily to acquire the society point of view than when there is free choice.

   But even in Copenhagen and Frederiksberg, as we have seen, inroads have been made on the district

doctor system. Control has thereby been made more difficult, and new measures have had to be taken.

The societies depend largely for the exercise of control on statistical data of each doctor's doings. It will be seen from the particulars given in appendix X, that the report of the Copenhagen Federation of Sickness Societies gives information of the average cost per member of the prescriptions of each of the doctors. This information affords valuable general indications where inquiry is necessary. It does not by any means serve of itself to convict, but it points the way for investigation.

Societies in Copenhagen at one time employed paid experts to check the prescriptions of the doctors, and to see that they did not order at the cost of the society things which were not so allowed, or more costly things than needed to be given. But it was found that the game was not worth the candle, and the societies fell back on statistical data. The information of the record of each doctor with regard to prescriptions is prepared at frequent intervals by some societies. Similar information can of course be prepared with regard to the doctors' records as to the certifying of persons as unable to work and other matters.

Members or their children cannot be sent to a hospital at the charge of the society unless a certificate is first obtained from the society. There is the less incentive to keep a stern check on the sending of cases to hospitals because of the exceedingly favourable terms on which hospital treatment is allowed, especially in Copenhagen (see chapter XVII). Indeed, the complaint rather seems to come from the doctors that the hospitals are being used to their detriment. At many places also the doctor is paid according to services rendered, and this reduces the temptation needlessly to send cases to hospitals. It is stated that generally in Denmark the demand for hospital accommodation is so much greater than the supply that there is an automatic check on abuse. But experience shows that this in itself is not an adequate safeguard.

None of the Danish societies employs a confidential medical adviser. In practice the large societies have some one doctor in their service—often the doctor patronized by the largest number of members—to whom they go when they require expert advice. But this informal arrangement is of course very different from the systematic employment of a confidential medical adviser with definite duties to uphold the interests of the society.

The doctors are endeavouring to secure that there shall be in the district of each local doctors' association some one doctor to whom matters of medical opinion in dispute shall be referred. They probably wish to put their house in good order to avoid outside pressure, fearing that if they themselves do not make good arrangements an undesirable form of control may be forced on them by the societies.

The advent of free choice of doctor has made new means of control imperative. Mention has already been made of the ticket system. This enforces control through the member. He has himself to pay a little before he can receive from his society, and unless he seriously requires the services of a doctor, he may not like to gamble on the issue. But great though the gains have been from this system, it only covers a part of the field of control.

The larger societies now make more use of paid controllers or visitors, in addition to voluntary visitors. These officers visit members on benefit to see that they are really unable to follow their employment, so far as a layman can judge, and are complying with the regulations of the society and the doctors' directions. Their employment adds to the cost of administration, but is said to be a profitable investment. I have not dealt with this form of general lay control in the present volume, but it may be mentioned that the German societies likewise rely much on paid lay controllers—though, as I was told in one place, they prefer to call them by a softer name ; and, of course, the officers are not only controllers, but counsellors also.[1]

[1] The Leipsic society employs over 20 paid officials of this kind. In addition it has over 300 voluntary visitors, who are most of them

There is systematic machinery for the discussion of matters of common interest and for settling disputes, machinery which is typical of the genius of the Danish people for democratic organisation.

1. For the discussion of matters of common interest, including terms of remuneration and methods of control, meetings are held between representatives of the local federations of sickness societies and the local doctors' associations. Except in Sealand, each of these organisations covers the same area as the "county." Matters of sufficient importance are referred to the general meetings of the respective bodies, and some matters to the central union of the federations and the central union of the doctors' associations.
2. There is further machinery for settling disputes arising under the existing agreements; generally—
   (*a*) If a dispute arises, it is first referred to a committee of conciliation, consisting of two representatives of the local societies' federation and two of the local doctors' association.
   (*b*) If the matter cannot be settled or if there is an appeal, it goes to a central committee of arbitration consisting of (i) four representatives of the societies selected by the central council which is chosen by the societies to advise and deliberate with the government Inspector on insurance matters generally, and (ii) four representatives chosen by the central union of the doctors' association. The representatives appoint their chairman. The committee can levy fines. It depends on the local federations and associations for enforcing its decisions.

This organisation for consultation and settlement of disputes, which relies on voluntary bonds for its efficacy, works admirably and costs little.

persons chosen by members to represent them at the general meetings. The voluntary visitors are not remunerated, but receive a "compensation" of 6 *pfennig*, (about 7¼d.) for each visit paid. They are allotted to districts, of which there are 31 in all each with a superintendent.

CHAPTER XII

Control of Medical Service

Conclusions

1. *It is essential that strict control should be exercised over medical practitioners in their treatment of insured persons, especially when there is free choice of doctors.*

It is scarcely necessary to elaborate the case for strict control. There are obvious reasons, many of which have already been mentioned, why it is essential, and practical experience confirms its need. Very instructive in this respect are the particulars given respecting Cologne and the large rise in expenses there when adequate control was wanting (see appendix IV).

The control has to extend to all departments of the doctor's work. Of course, a wise control will not interfere, other than in very exceptional circumstances, with a doctor's treatment of a case. But it is necessary to be assured that the doctor gives reasonable attention and good treatment to his patients. The latter have a right to expect that their society will see to this.

Then the society, or other authority responsible for medical benefit, must take steps to protect its own interests, to see that a doctor does not too complaisantly or readily give certificates of inability to work; that he adopts reasonable precautions to detect malingering; that he does not multiply work by unnecessary visits; that he does not order, at the expense of the society, medical or surgical requirements for which the society does not undertake to pay—or needlessly expensive requirements if it does pay—and so forth.

If a doctor is paid by capitation fee, it may seem to be his own business whether he multiplies work. But should he pay unnecessary visits and the like, increased work would probably be brought forward later as a reason for an increased capitation fee. So that even in such a case the society does well to exercise control. Further, societies often pay special fees for some services—for operations and difficult midwifery cases, for instance.

It is not simply that the society needs to exercise strict control to make its work more profitable. Economy is an essential of working-men's insurance, and it cannot be secured unless there be strict control. Without stern economy, or such a subsidy as would make the scheme more one of charity than of mutual protection, working-men's insurance is in constant danger of bankruptcy.

2. *Detailed control in expert matters should be exercised mainly through the organisation of the doctors themselves.*

Doctors strongly resent lay control. In part, no doubt, the resentment is selfish—largely human nature, the restiveness of the expert under lay control. And the control is not the more acceptable in that it comes from persons of a lower social standing. It is also the more irksome in that the doctors often feel that they are compelled to work for low remuneration and under unfair conditions.

And clearly, in some ways, the resentment of the doctors is not without reason. They often feel that those who exercise the control are ignorant of the nature of the medical work and of the many difficulties with which doctors have to contend, and that they demand a sovereign's worth of labour for a shilling of pay. The bond of sympathy is wanting.

The difficulties which have been mentioned point to the conclusion that expert should control expert.

The same conclusion is reached if we consider the question from the point of view of efficiency. The work

of an expert can be properly criticised in matters of detail only by an expert. The layman may succeed in checking abuses in one direction; but he can probably be easily circumvented in another if the expert be so minded, and, in the time that he takes to master that other, the expert can probably devise half a dozen new ways of gaining the upper hand. The layman, when he tries to control the expert in matters of detail, is likely only to become entangled in the meshes of the intricate net. His control will prove clumsy and ineffective.

But could not the society employ its own "tame" expert for purposes of control? There are objections to this.

(*a*) The society, or a group of societies, could probably not afford to pay sufficient remuneration to attract the best qualified men. There would be danger that the person employed would not have ability enough to detect or authority enough to withstand.

(*b*) If the society or societies employed an expert whom they engaged for only part of his time, there would arise the further complication that he would probably be in business relations with those whom he had to control, perhaps even partly dependent, if he were a specialist, upon them for his practice.

(*c*) Lastly, it must not be forgotten that, after all, the best control is confidence and sympathy between society and doctors. These absent, and any system of control is likely to fail of much success. These present in a large measure, and almost any system of control becomes easy. And this feeling of confidence and regard is the more important in the matter of medical treatment because the work is not one to be easily gauged or one in which defects can be readily detected. It cannot be measured by scale or compass. A wide reliance must be placed on the practitioner.

A system by which control is exercised from outside is faulty in that it tends to separate the

sickness society and the doctors. On the other hand control exercised through the doctors with judicious supervision engenders confidence and respect.

In Germany there appears to have been a definite trend towards relying on the control of the practising doctors themselves, a trend interrupted, it is true, by the hostility of doctors and sickness societies which has flared up afresh on the occasion of the new law, but a trend which is almost certain to develop. Leipsic affords one of the best examples of the system.

But it will be obvious that doctors cannot be entrusted with liberal control over medical service except on condition that they rise to the occasion. And for this it is not sufficient that they have the will and the ability. They need also—this is essential—to see things from the point of view, not only of their own interests, not even simply from the point of view of medical treatment, but also from the point of view of the workman, with his struggle close to earth, with his narrow means compelling him to live close to the hard core of things, consequently with his often hard, stern standards of judgment, which may seem harsh to those more easily circumstanced. But, as already stated, these hard, stern standards are essential to the success of working-men's organisations, and in very self-defence the workman emphatically cannot leave a liberal control of his interests to the doctor except on condition that the doctor sympathetically realises in practice the essential needs of his circumstances.

And not the least of the advantages of a system of control such as that outlined is that it provides a constant means of educating workman and doctor in their several needs and ideas. Things are at the same time much more complicated and much simpler than they seem to the superficial eye. What has already been written respecting control of medical benefit is sufficient to show how it is woven and interwoven with problems. At the same time it is manifest

that one of the essential factors for efficient service is mutual confidence and mutual understanding. Most important is it, therefore, that arrangements be adopted which will not militate against sympathy and understanding, but, on the contrary, will foster them in the highest degree. And this primary need is satisfied by a system such as that advocated.[1]

3. *The sickness society or other pertinent insurance authority should exercise strict general control through its own committee, assisted by a confidential medical adviser.*

As was stated, the handing over of the details of expert control to a committee of the doctors does not mean that the society will abrogate its own right of control. Rather will this be exercised even more strictly, but, instead of being scattered on a tangled mass of expert minutiæ, it will be concentrated on broad policy and results, and will thus be the more effective.

The particulars which are given of the return made by the Königsberg district society (p. 118), and of the work of the Copenhagen federation (p. 122), give some indication how this may be done. For example, the periodical statement of the expenditure, per person treated, on drugs, &c., ordered by each doctor gives a broad basis of control in that matter. Not that, if in the case of a particular doctor the cost happens to be high during some period, it necessarily follows that the doctor has been lax. There may have been special circumstances. But the high cost shows that there is need of inquiry to ascertain whether there have, in fact, been such circumstances.

The lay committee will need the aid, even in broad control, of an independent expert—a confidential medical adviser. Otherwise they may blunder badly. It will not be practicable for each society, or branch of a society, to employ its own adviser. Societies might band together to employ some person in common. This is done in Germany ; the case of Düsseldorf has been cited.

[1] Equally important is it to take full advantage of the *esprit de corps* of a professional group. This is done under the system here suggested, especially when payment of remuneration in the manner proposed in p. 90 is adopted.

But the lay committee, in its use of its medical adviser, should be careful not to undermine the authority of the doctors' committee; otherwise the problem of control may be made more difficult, not easier. Disciplinary measures against any doctor should always be taken through the doctors' committee where possible.

Those who are familiar with local administration will be struck by the analogy between the problems of control which confront a local authority, and those which confront an insurance society. Local authorities in many cases have not yet evolved a satisfactory system of control. On the one hand, it is constantly said that committees are run by their own expert officials; on the other, that committees dabble, with disastrous results, in the intricacies of expert work. Both criticisms are too often true. A committee frequently forgets that its work is administrative, not executive; that it is its business, not to do the work of the expert, but to see that the expert does his work effectively and economically; that the only way to exercise its functions of public trustee and guardianship is to determine broad policy, to keep free from detailed execution, and to judge ruthlessly by results. The problem which confronts the insurance society or other authority is essentially the same; it is, in fact, a problem of democratic control.

Where the same authority administers disablement as well as sickness insurance, the employment of a confidential medical adviser is the easier because there will be more work of a kind to be done by such officers. His services, as already stated, will be very important in determining whether disablement benefit should be given, especially in doubtful cases.

4. *Provision should be made for committees of conciliation and of arbitration.*

By committees of conciliation are meant committees, containing representatives of the insured and of the

doctors, where common interests can be discussed and disputes settled without the intervention of any third party; by committees of arbitration, committees containing, in addition to representatives of the insured and of the doctors, also independent third parties to smooth over difficulties and, in the extreme, to give deciding votes in disputes which cannot otherwise be settled.

The admirable scheme at Leipsic provides, as we have seen, fully for such committees, and the need of them has been felt generally in Germany; and is likely to be felt still more if the clouds which now overcast the insurance sky break in their violence.

The reasons why such committees are needed are manifest. The ways and notions of doctors and of workmen, their training and their mode of life, and at times their interests, are so different that, unless there is to be much misunderstanding, there must be some systematic provision for the interchange of views. And in the best regulated scheme disputes will surely break out. The best way of preventing their becoming serious is to provide systematic means for their prompt settlement, settlement without the interference of third parties if it be possible, but, if that be not possible, then with judicious intervention.

5. *There is much advantage in securing some control of medical benefit through the patient, a control which is obtained if the patient has a direct and immediate pecuniary interest in preventing abuse.*

This matter has already been considered in chapter IX, p. 92, where the very great gain of making the patient pay out of his own resources for part of the cost of medical treatment was considered.

CHAPTER XIII

Medical and Surgical Requirements

GERMANY

The sickness insurance law requires that medicine and spectacles, trusses, and the like, shall be provided as part of benefit. The provision of exceptional requirements, whether medical or surgical, is optional.

Within these limits, therefore, each society decides for itself, in its regulations, what shall be comprised in the benefit given. Most societies appear to confine themselves, so far as the regulations go, to providing that the minimum benefits stipulated in the law shall be granted. The terms of the law, however, are obviously vague, and therefore, even when the same form of words is adopted by societies, they may be interpreted somewhat differently according to the temper of the administration and the state of the funds.

Many societies have special provisions in their regulations with regard to the supply of medical and surgical requirements. Thus, the regulations—

of the Leipsic district society provide that the society, at the direction of the committee and up to a maximum of 75s. in any case, may contribute to the provision of the more costly requirements, such as orthopædic instruments, artificial eyes or teeth ;

of the Dresden district society, that wine needed for treatment may be supplied on condition that not more than 300 grammes is ordered in a prescription or more than 1,200 grammes in all for the case; and also that milk may be prescribed, at the expense of the society, but not more than 1 litre a day and for not more than six weeks ;

of the Düsseldorf district societies, that dental filling may be given as part of benefit if shown to be necessary, by a doctor's certificate, for the recovery or maintenance of health.

Another source of difference is the practice in regard to the supply of requirements to dependants, when these are provided with medical treatment as part of benefit. Many societies—among others the Dresden and Düsseldorf district societies—do not pay any part of the cost of medical and surgical requirements for dependants. The Leipsic society provides medicines but not other requirements. Some societies pay only part of the cost ; thus the establishment society of Messrs. Blohm and Voss, Hamburg, pays one-half of the cost of medicines. Moreover, as previously stated, the period for which benefit is given to dependants is generally shorter than for members themselves.

The general conditions with regard to the supply of medicines are very different in Germany and other continental countries from those in England. Medical practitioners are not allowed to dispense medicines, except by special permission. Dispensing is the monopoly of pharmacists who have passed an examination qualifying them for the work.

But when a person has become qualified he is only through part of his journey. He cannot open shop and start retailing his wares and skill to the public. That pharmacist alone can do this who has been licensed by the public authority, and these concessions are not easy to get, for public authorities restrict the number of shops to the number which they think will be needed for supplying the public. In other words, the pharmacist is virtually given a monopoly in his neighbourhood.

He is not, however, then allowed to fleece his public at his will. Prices are officially fixed, and more may not be charged. The pharmacists, too, are closely supervised to see that they carry on their business properly, and that their drugs are of good quality and are not stale.

The position of the pharmacist, with so much supervision, has its drawbacks, no doubt, but his security of tenure and his practical monopoly make his position an enviable one in many ways. The official tariffs have been liberal, and pharmacists have thriven. Judging from what I was told, I doubt whether the ordinary pharmacist is not at many places as well off as an ordinary doctor. Sometimes a military doctor, on retiring, will turn pharmacist, and such applicants for concessions are favoured by some public authorities.

In the past there has been much speculation in pharmacists' businesses. The goodwill of a business could be sold. Financiers would buy a business, working it, of course, through a properly qualified person, and then, when there was a heavy increment in value, would sell it. Very large sums have been sometimes made in this way. This unsatisfactory condition of things is to be prevented in future. The goodwill of future concessions is not to be a matter of private property; the concessions, when re-granted, will be sold by the public authority, and the proceeds will go to the public purse.

One incidental disadvantage of private property in such businesses under the conditions in Germany is that it creates a vested interest in the maintenance of prices. Buyers of businesses consider that they have the right to recoup themselves for a heavy initial outlay by charging high prices to the public. It seems likely that in the past prices have been maintained above their competitive level. There have been some reductions in recent years.

Pharmacists have a monopoly of the sale of only certain medical and surgical requirements. The many other preparations and contrivances which men use in their distress, some kinds of drugs, patent medicines, apparatus, and the like, can be sold by druggists. These do not need to have special qualifications or a special licence to ply their trade. They are a constant thorn in the flesh of the pharmacists, who bemoan their competition —and of the authorities too, who are kept busy in

preventing their encroaching on the monopoly of the pharmacists.

The provisions of the new law with regard to the supply of requirements of which pharmacists have not the monopoly are of interest. The higher administrative authorities are given power to fix the maximum prices at which such articles shall be supplied, due regard being had to local conditions. Societies may make arrangements for the supply of these requirements, but the authorities may stipulate that, if prices have been fixed and a member chooses to go for such a requirement to a pharmacist who supplies it at not more than the fixed price, the society cannot refuse to pay on the ground that the article could have been obtained more cheaply elsewhere. Apparently, therefore, in such a case, if the society had made more economical arrangements than buying at the prices fixed by the authorities would be, the advantages of these arrangements would depend on the extent to which they were voluntarily observed by the members. But a society would have more than one way of indirectly making its power manifest to a recalcitrant member.

Under the old law it was left to the societies to arrange with the pharmacists for the supply of drugs. As may be expected in the case of persons with an effective monopoly, the latter are generally well organised. Pharmacists, equally with doctors, are in favour of free choice — of allowing the patient to take his prescription to what pharmacist he pleases. As a rule, all the pharmacists in the district undertake to allow the same terms to societies, and the latter permit their members to go to any of the pharmacists to have their prescriptions made up.

Under the new law pharmacists have practically "free choice" guaranteed them. Sickness societies are permitted to make special agreements with pharmacists, but any pharmacist is to be allowed to supply members of the society on the terms of the agreement.

Pharmacists generally allow societies a liberal discount

on the officially fixed prices. The rate of discount differs widely, being as high as 25 per cent. in some cases and only 10 per cent. in others. In the new law it is provided that a discount must be given to sickness societies, and that the authorities are to decide the amount of the discount.

There have been disputes between sickness societies and pharmacists at some places, among others at Cologne, now the theatre of bitter strife between societies and doctors. Disputes have occurred there on two occasions, because the pharmacists would not give to sickness societies such favourable terms as the latter considered were warranted. The societies and the pharmacists' association tried various devices to bring each other to terms. The pharmacists refused to dispense prescriptions except for cash, and the societies had to resort to devices to meet this manœuvre. The societies, on the other hand, restricted the purchase of drugs to a few pharmacists; but this was not very satisfactory because, by agreement between the pharmacists, those who got the business paid over part of the proceeds to their dispossessed brethren. To overcome this strategy, the societies got the prescriptions, other than those which were urgent, made up by persons outside Cologne. Ultimately, the two combatants came to a satisfactory compromise.

Another arena of strife is Düsseldorf. There the pharmacists were not prepared to give more than a discount of 10 per cent. The district societies thought they should receive more, and, as the pharmacists stuck to their position, refused to enter into a new agreement. The pharmacists nevertheless give the 10 per cent. offered.

One of the reasons for the strained feeling between societies and pharmacists at Düsseldorf is the supply of, and the charges for, what may be termed medical and surgical merchandise—materials and apparatus used for treatment of sickness, but not coming within the category of goods which may be supplied by qualified pharmacists

only. Pharmacists would naturally like, in their agreements with sickness societies, to have a monopoly of the supply of these articles also. But the societies do not like to tie themselves too tightly.

The Düsseldorf district societies now themselves supply to their members some of the medical and surgical requirements which are not monopolised by pharmacists.[1] Doctors are requested to prescribe, if possible, such articles as are kept in stock if any such be needed for treatment. A prescription has first to be brought to the offices of the society of which the patient is a member. Such articles in the prescription as are in stock are supplied from the store of the society, and the prescription, duly endorsed, may then be taken to a pharmacist for the supply of the other things ordered. Prescriptions are systematically checked to see that doctors do not order things not kept in stock when things which are kept in stock would have done equally well. The Düsseldorf district societies are very well satisfied with their scheme, and say that it has saved their funds considerably.

Many other societies have a similar system, and the practice appears to be growing. It is aided by the existence of district federations of societies through which purchases can be more advantageously made than if each society bought separately. Buying in large quantities the federation has the opportunity of getting goods at cheaper rates than would be possible by retail purchasers. Furthermore, they can make sure of the quality. No doubt there is danger that a society may restrict itself to a narrowly limited stock, and unduly hamper the doctor in his prescriptions. But with liberal and wise administration this danger should not be great.

[1] It appears that, until the agreement with the pharmacists was terminated in 1910, goods of this kind had to be purchased through the pharmacists' association, though the societies could negotiate themselves with the wholesale firms as to the prices, on which, however, the pharmacists received a percentage.

It is necessary that prescriptions and their dispensing should be duly checked.—

1. The work of the doctor has to be checked.

The question has already been considered in some of its aspects. Societies have to see that the doctors do not order drugs or other requirements which are not allowed by the rules of the societies. I have before me a list of drugs, with their prices, which the doctors of one of the German societies are allowed to order. The doctors of this society have to keep within this list. Then again, as already pointed out, societies have to take precautions to secure that their doctors do not order expensive drugs when other cheaper drugs would be equally satisfactory.

Where there is free choice of doctor, some agreements between doctors and sickness societies provide that, subject to certain conditions, if a doctor has ordered more drugs, &c., at the expense of the society than seem to have been necessary for a case, or drugs which are unnecessarily expensive, the excess charge may be deducted from the remuneration payable to him—see, for instance, the particulars given in appendix V, p. 257, respecting the agreement at Leipsic.

It has been stated in a previous chapter that the work of checking the prescriptions of the doctor is in some places allotted to a committee of the practising doctors, while at other places, this forms part of the work of the confidential medical adviser. Some societies employ pharmacists for this work. Doctors generally do not like this arrangement; they object to the lay control, and consider it derogatory and impracticable that their work should be subjected to the revision of a person of lower professional standing.[1]

The checking of prescriptions appears to be carried on by some persons as a business, and societies sometimes send the prescriptions of their doctors to be checked by persons living far out of the district. Thus, the Hamburg authorities at one time sent their prescriptions to

[1] Nominally of course the pharmacists do not check the expressly

Cologne to be checked by a pharmacist. There are doctors also who undertake the work. The federation of establishment sickness societies undertakes to arrange for the checking of prescriptions on behalf of its affiliated societies.

Again, it is important to see that the prescriptions are made by the doctors with due care. One of the matters which gives rise to trouble is that of repeat orders. Doctors are accused of giving repeat orders too freely. It saves them so much trouble just to use some brevity, instead of having the labour of writing out a fresh prescription in full. It has been advocated, therefore, that where a prescription is repeated the doctor should be required to write it out afresh. It is thought that more care would thus be secured.

2. The pharmacist has to be checked no less than the doctor. It is necessary to safeguard—
   (*a*) That he charges correctly for the prescriptions. This is primarily a matter of accounts.
   (*b*) That there is no collusion between pharmacists and doctors or patients. Evils of this kind have not been unknown. A society must largely trust to the pharmacist and doctor, but occasional checks are necessary.
   (*c*) That prescriptions are correctly made up and that the drugs supplied are of good quality. As regards the latter point, the societies in Germany need not do much in this direction, having regard to the strict control to which pharmacists are there subjected by the public authorities. The requirement that every pharmacist shall be duly qualified provides some security for the former, but independent check has to be superimposed on this.

As with doctors so with pharmacists, control is rendered more difficult by the existence of free choice. Control may, however, be exercised partly through the association of the organised pharmacists.

medical side of the work, but the question depends on where the line is drawn between the medical and the pharmaceutical.

Medical and surgical requirements are a source of heavy expense to the German sickness societies. In 1910 the sickness societies and the communal insurance funds, excluding the miners' societies, spent over £2,400,000 under this head, being an average of 3s. 8d. per member. The average cost per member varied in the different insurance groups from 4s. 10d. in the establishment societies, and 3s. 8d. in the district societies, to 2s. 2d. in the communal insurance funds (A).

The following are particulars of the expenditure in 1910 on medical and surgical requirements of some large district societies—

(*a*) per member on the average,

(*b*) per cent. of the total expenditure of the society.

(The numbers in brackets show the average membership during the year.)

		(*a*) s. d.	(*b*) Per Cent.
Leipsic	(182,898)	4 4[1]	11
Munich	(125,142)	4 0	9
Dresden	(119,419)	4 5	14
Hamburg (employees)...	(55,897)	3 7	9
Cologne (miscellaneous)	(25,634)	4 8	14
Königsberg	(23,200)	4 3	12
Kiel	(20,844)	6 3[1]	14

It will be seen that in only one of these societies did the cost fall below 4s., and these are types of the better societies. The cost was from 9 to 14 per cent. of the total expenditure.

A number of considerations have to be taken into account in order to appreciate rightly the significance of these figures.

(*a*) The cost only of requirements provided for domiciliary treatment is included. The cost of drugs, &c., provided in cases treated at institutions is generally included in the cost of institutional treatment.

[1] Of these amounts, 1s. 4d. in the case of Leipsic, 1s. 11d. in the case of Kiel, is said to have been in respect of medicines, &c., provided for dependants of members. Of the other societies, that at Hamburg provides medicines for dependants; that at Cologne pays half the cost, but members have to pay a special contribution if they wish benefit to be provided for dependants, and comparatively few do so.

(*b*) Much more is included than ordinary drugs. At the close of the chapter particulars are given of the items included under the heading of medical and surgical requirements in the case of some societies (D, E). Germans think highly of special "baths" as curative agencies, and the expenditure under this head is generally heavy—Leipsic, £4,400 out of a total of £40,000; Munich, £1,500 out of £24,900; Dresden, no less than £5,600 on baths and massage out of £26,200. The latter society spent also nearly £3,000 in milk; but so extraordinarily high an expenditure on this item seems to be exceptional.

But although the expenditure on exceptional items is in some cases heavy, the main source of expense, as will be seen from the particulars furnished, is generally the ordinary medical and surgical requirements.

(*c*) As previously mentioned, the cost of medicines supplied to dependants is included in some cases.

There has been a very heavy increase in the expenditure on medical and surgical requirements. Statistics are given at the close of the chapter of the expenditure in the different kinds of societies, and in the Leipsic society in particular, for a series of years (A, B). It will be seen that, whereas the district societies of Germany spent in 1888, on the average, less than 2s. per member on drugs, &c., in 1908, they spent 3s. 6d., and in 1910, 3s. 8d. The Leipsic society spent 2s. 4d. in 1888, 3s. 5d. in 1908, 4s. 4d. in 1910. The Munich society spent 3s. 4d. in 1904, 4s. in 1910.

What are the causes of the heavy increases? The following are among them.—

(*a*) There has been an increase in the prices of some goods.

(*b*) There has been an extension of benefits.

It has been stated that the legal minimum period of benefit was increased in 1904 from 13 to 26 weeks; but this would not account for very much increase in cost. Medical and surgical benefits have been given on a

more liberal scale by some societies. There has been an extension of the giving of benefits to dependants; but we have seen that benefit to dependants does not always carry payments for drugs, &c.

(*c*) Medical treatment has become more elaborate.

More use is made of expensive drugs. Against this has to be set the fact that doctors often rely more on dietetic and similar treatment.

(*d*) There has been an increase in the average number of days of sickness for which benefit is given.

Reference has been made to this question in dealing with the remuneration of doctors.

(*e*) The increasing freedom given to members in choosing their doctor has no doubt had an important influence.

Increased expenditure on drugs, &c., is one of the charges brought by the societies against the system of the free choice of doctor. It is alleged that, when there is free choice, some members go to doctors who are most complaisant in giving them what they desire.

(*f*) There appears to be no evidence that the insurance scheme of Germany has had any marked effect in reducing the credulity of human nature in the efficacy of drugs.

A German doctor experienced in insurance practice writes: "In ordinary private practice the sensible and educated patient generally is content if the doctor, after examination of the case, orders something that can be supplied in the household or a temporary special diet. The society patient wants more; above all, he wants a prescription. He pays his contributions and, in fact, will not rest satisfied if the doctor contents himself with simple remedies which have not to be fetched from the pharmacist. So unreasoning, in many cases of sickness, is the immovable belief in prescriptions that the doctor has to reckon with the suggestive influence of the belief."[1]

[1] M. Fürst; Der Arzt; p. 93.

And the vendor of patent medicines still seems to have a ready public. Germany has now had over a quarter of a century of compulsory sickness insurance. It might have been reasonably expected that one result of the insurance would have been the education of the public against credulity in quack medicines. But there does not seem to have been any such result. This cannot but be regarded as a disappointing feature of German insurance.

The sickness societies are alive to the gravity of the heavy expenditure on drugs, &c., and, as previously shown, strong measures of control are adopted. The heavy expenditure under this head was one of the reasons which induced the district societies of Saxony to request the government to establish at the Leipsic University systematic provision for researches into, and for the teaching of, nature treatment.

A.—German Sickness Societies: Average Expenditure (to the nearest Penny) per Member in the several classes of Sickness Societies and in Communal Insurance on Medical and Surgical Requirements

D. District societies.
E. Establishment societies.
C. Contractors' societies.
G. Guild societies.
Cm. Communal insurance funds.
V. Registered voluntary aid societies.
S. Registered State aid societies.
T. All the societies and insurance funds.

Year.	D.	E.	C.	G.	Cm.	V.	S.	T.
	s. d.	s. d.	s. d.	s. d.	s. d.	s. d.	s. d.	s. d.
1888	1 11	2 11	2 1	1 3	1 3	0 7	0 9	1 10
1893	2 5	3 8	2 5	1 8	1 7	1 8	2 0	2 6
1898	2 5	3 6	2 7	1 10	1 6	1 11	2 4	2 6
1903	2 10	3 10	2 11	2 4	1 8	2 0	2 7	2 10
1908	3 6	4 7	3 2	3 0	2 1	2 7	3 1	3 6
1910	3 8	4 10	3 4	3 0	2 2	2 8	3 1	3 8

B.—Leipsic District Society

(*a*) Average expenditure per member on medical and surgical requirements.
(*b*) Percentage of the expenditure on medical and surgical requirements of the total expenditure.

Year.	(*a*) s. d.	(*b*) Per Cent.
1888 ...	2 4 ...	12.0
1893 ...	2 9 ...	12.0
1898 ...	3 5 ...	13.0
1903 ...	4 1 ...	14.0
1908 ...	4 1 ...	10.0
1910 ...	4 4 ...	11.0

C.—Cologne District: Average Expenditure per Member in 1909 of the Sickness Societies in the Cologne District on Medical and Surgical Requirements

Number of Societies with Expenditure as shown in the first column.

	District societies.	Establishment societies.	Guild societies.	Total.
Over 7s.	—	9	—	9
5s. and over, but under 7s. ...	1	15	—	16
4s. „ „ „ 5s. ...	9	17	—	26
3s. „ „ „ 4s. ...	4	15	4	23
Under 3s.	1	6	2	9
Total	15	62	6	83
Average expenditure per member	4s. 3d.	6s. 1d.	2s. 10d.	4s. 8d.

The five highest expenditures were in the establishment societies of the—

"Powder-makers Syndicate"	14s.	per member
"The Gas, Electricity, and Water-works of Cologne Town"	12s. 9d.	„ „
"The Municipal Tramways"	9s. 8d.	„ „
"The Urban Commune of Cologne" ...	9s. 3d.	„ „
"The Building and Decorative Stone Works," Gottfried Riphahn ...	9s. 1d.	„ „

These are very high figures. That so many public establishment societies should come within this group seems significant.

D.—Details of the Expenditure in 1910 on Medical and Surgical Requirements

(1) *Leipsic District Society*

£
31,483 was expended on ordinary medical requirements, including wine and dressings.
8,512 was expended in addition on special requirements.

The items included in this £8,512 were—

£
4,389 for baths.
1,274 for spectacles, &c.
1,246 for trusses, &c.
621 in contribution towards cost of artificial teeth.
477 for milk.
341 for electrical treatment.
146 repaid to members.
14 for artificial eyes.
4 for ice.

The drugs, &c., were ordered in 773,333 prescriptions, each prescription representing on the average a cost of 1s. 0¼d.

(2) *Munich District Society*

£	£		
20,017		was paid to the Munich Association of Pharmacists.	
1		,,	to various Munich pharmacists.
218		,,	to pharmacists outside Munich.
	20,236		
1,150		,,	for trusses, flat-foot appliances, &c.
768		,,	for spectacles, &c.
23		,,	for artificial eyes.
1,501		,,	for baths.
523		,,	in contributions towards cost of artificial teeth.
	3,965		
	280	,,	to various clinics, &c., in payment for dressings.
150		,,	for the checking of prescriptions by doctors.
218		,,	for the checking of prescriptions by pharmacists.
	368		
	5	,,	in respect of the confidential advisers' department.
	1	,,	in respect of the department of the society for medical requirements.
	£24,855	Total.	

(3) *Dresden District Society*

£		
15,136	was paid to pharmacists.	
5,567	,,	for baths and massage.
1,801	,,	for surgical appliances and for some requirements provided by cure establishments.
698	,,	to opticians.
2,956	,,	for milk.
£26,158	Total.	

The £15,136 paid to pharmacists was for prescriptions, divided as follows:—

	Number of patients.	Number of prescriptions.	Average cost per patient.
Male patients ...	63,826	136,729	2s. 4d.
Female „ ...	59,560	127,296	2s. 7d.

(4) *Cologne District Society for various Employees* (*Cologne, Miscellaneous*)

The expenditure of this society, the largest in Cologne, is specially interesting because of the conflict between doctors and sickness societies. From April, 1904, to January, 1909, medical service was given under an agreement made between the supervisory authority and the organised doctors at Cologne against the will of the society. This agreement provided for the free choice of doctor. The society alleged that expenditure on drugs, &c., was much increased in consequence.

The following table shows—

(*a*) Expenditure (to nearest £1) on drugs.
(*b*) „ „ milk.
(*c*) „ „ wine and brandy.
(*d*) „ „ spectacles.
(*e*) „ „ baths.
(*f*) „ „ other requirements, including part payments towards cost of artificial teeth.
(*g*) Total expenditure on medical and surgical requirements.
(*h*) Average expenditure per member on medical and surgical requirements.

Year.	(*a*)	(*b*)	(*c*)	(*d*)	(*e*)	(*f*)	(*g*)	(*h*)
	£	£	£	£	£	£	£	s. d.
1903	2,283	523	46	144	114	243	3,353	3 7
1904	3,338	433	25	190	153	264	4,404	4 4
1906	5,160	386	14	268	247	406	6,481	5 6
1908	5,164	725	8	243	282	448	6,869	5 6
1909	3,654	529	9	212	197	601	5,203	4 2
1910	4,417	555	11	248	218	496	5,945	4 8

E.—Königsberg District Society

The following are particulars of medical and surgical requirements supplied to members of the society in 1910—

Number of prescriptions for—	
Drugs and dressings	126,623
Wine and brandy	83
Milk	1,399
Spectacles, trusses, surgical appliances, &c.	3,703
Baths, massage treatment, cupping, &c.	3,445
Total	135,253

Average per member	5·8
„ „ case of sickness	3·4
Total cost of medical and surgical requirements ...	£4,953
Average cost per prescription	9d.
„ member	4s. 3d.
„ case of sickness	2s. 7d.

Among the requirements supplied were—

1,695 spectacles.
291 trusses.
176 irrigators.
152 suspensory bandages.
186 syringes.
32 nasal douches.
78 elastic stockings.
87 abdominal belts.
332 flat-foot appliances.
52 inhalers.
13 ice-bags.
12 artificial eyes.
40 clinical thermometers.

Also—

8,753 massage treatments.
2,192 Roman baths (similar to Turkish or Russian baths).
3,821 ordinary baths.
190 light baths.
856 electric baths (4 cells).
516 orthopædic treatments.
441 X-ray treatments.
444 cuppings.

And on loan—

9 electrical induction apparatus.
84 apparatus for hot air baths.
18 baths.
9 electrical apparatus.

In 21 cases the society paid part of the cost of expensive requirements, more especially artificial teeth, provided by the invalidity insurance authorities.

CHAPTER XIV

Medical and Surgical Requirements

DENMARK

The general conditions in Denmark as regards the position of pharmacists are very similar to those in Germany. Only persons expressly qualified as pharmacists are allowed to dispense. Medical practitioners are not allowed to do so unless specially permitted. Pharmacists cannot open a shop except by license of the authorities. The number of licenses granted is restricted according to the population to be supplied. Pharmacists are closely supervised, and the prices of drugs are officially fixed.

But the Danish insurance law, contrary to that of Germany, makes no provision with regard to the supply of drugs, &c. A society may provide these requirements or not as part of benefit, or may only pay part of the cost, at its option.

A table at the close of the chapter shows the number of societies which provide ordinary medicines as part of benefit.[1] In Copenhagen and Frederiksberg, nearly 90 per cent. of the societies do so; in the provincial towns, less than one-half; in the rural districts, comparatively few. It has to be remembered that the societies with large membership are in the towns, especially in the capital district, so that a larger proportion of members receive medical and surgical requirements as part of benefit than might appear from the number of societies which provide this benefit.

A large number of societies pay part of the cost of ordinary medical and surgical requirements. At the beginning of 1906, over 600 societies, out of a total

[1] The Danish societies do not provide much beyond medicines. Information is given later (p. 283, column C (*c*)) of the expenditure on dressings, trusses, baths, &c., of some societies.

of 1,380, paid some part of the cost; 18 per cent. of the societies paid the whole cost, but over 20 per cent. paid not more than one-half of the cost (C).

This practice of paying only part of the cost of medical and surgical requirements finds much favour with competent observers of insurance in Denmark. It is strongly supported by the present and past State inspectors of sickness societies. Experience has shown that, when a member has himself to pay part of the cost of requirements, the total expenditure on them, including that met by the member himself, is much less than when the society pays the whole cost. When the member has to pay part of the cost out of his own pocket, he is not likely to obtain medicine unless he really wants it, and, when he gets it, he will be careful to be economical in the use of it. When he can get his medicine wholly at the expense of his society, he is apt to be thoughtless and reckless in getting and in using it.

A further advantage of requiring the member himself to pay for some part of the cost of medical and surgical requirements is that this practice is a useful check on unnecessary resort to the doctor. The member may have to pay out of his pocket for part of the results of the visit—for part of the cost of the prescription—and he is therefore encouraged to think before he makes a call on the doctor's services.

The Danes are stated not to be given to the use of patent medicines, and in this respect they seem to be in advance of the Germans. The prevailing insurance scheme is thought to have played a part in promoting this healthy scepticism towards quack medicines.

In Denmark, as in Germany, members are generally allowed by their societies to obtain their medicines from any pharmacist. The pharmacists are well organised, having district societies, federated into a central union, as in the case of the doctors. They allow special terms to the sickness societies; at Copenhagen, a discount of one-

seventh. Some sickness societies which do not pay for all drugs, &c., required by their members arrange with the members that they, the societies, will pay in the first instance for what is obtained, and shall then be reimbursed by the member concerned with his share of the cost. In this way the members secure the advantage of the discount allowed by the pharmacists.

With regard to the control over the provision of medical and surgical requirements, this is easier because the societies are generally small. Furthermore, in Copenhagen and Frederiksberg—the only places where there are large societies—the practice of employing district medical practitioners is followed: this further facilitates control.

As already stated, the report for 1909 and 1910 of the federation of sickness societies in Copenhagen contains particulars of the average expenditure per member allotted in the case of each of a number of doctors in the services of societies affiliated to the federation. A summary of the information afforded is given in appendix X. The cost per member averaged between 2 and 3 kroner (2s. 3d. and 3s. 4d.) in the case of most doctors, but in the case of many it was over 3s. 4d., the highest being nearly 4s. per member. As stated in the appendix, the figures have to be interpreted with much caution. Obviously, it would be wrong to expect an equally low expenditure from every doctor. Some may have had cases which necessitated a heavy expenditure on drugs. But the figures serve as useful indications where enquiry may be necessary, and are essential for proper control.

In the year 1909, the sickness societies expended a total sum of £45,400 on drugs, dressings, trusses, &c. This expenditure formed 12 per cent. of the total expenditure of the societies. But it is important to remember that some only of the societies pay for drugs, &c. Moreover, some societies which provide these requirements for

members do not provide them for dependent children entitled to medical treatment.

Particulars are given at the close of the chapter of the expenditure in 1909 of the societies which paid for all ordinary medicines as part of benefit (A, B). The average cost in these societies was nearly 3s. per member. It was highest in the case of societies in provincial towns, lowest in rural societies. It may be mentioned that the average expenditure of the German district societies was 3s. 7d. in 1909.[1]

It is of interest to know how the different societies compare with one another in the expenditure on medical requirements. Taking the particulars in appendix X, p. 281, of the expenditure in 1910 of the several Copenhagen societies on medicines, the average expenditure of the sixty-six societies was 3s. per member. But this included five societies which did not pay any part of the cost of drugs required by their members and some societies which paid only part of the cost. In fifteen societies the cost was over 3s. 4d. per member, over 4s. 5d. in four of them. The majority of the societies, thirty-eight in all, paid from 2s. 3d. to 3s. 4d. per member.

As in Germany so also in Denmark, there has been a very heavy rise in the expenditure on medical and surgical requirements. Thus, taking only the societies which paid the cost of all ordinary medicines, the average expenditure per member was under 2s. 1d. in 1893 ; by 1900 it had risen to over 2s. 8d., and in 1909 it was nearly 3s. (A).

It will be seen that the rise was heavier in the former than in the latter period. It has been proportionately larger in the provincial towns and the rural districts than in the capital district, a fact which is attributed in part to the free choice of doctor which is generally conceded by societies in the former places.

The causes of the rise have been similar to those which have been in operation in Germany, with the important difference, to which reference has been previously made, that, whereas in Germany the average period per member

[1] But the German figure includes expenditure on medical and surgical requirements other than medicines.

for which money benefit is paid or institutional treatment given has risen, in Denmark it has fallen. There do not appear to have been any important changes in the prices of drugs, &c., since 1892.

A.—Denmark: Average Expenditure per Member on Medicines in Societies which pay the Full Cost of Ordinary Requirements.

Year.	Societies in				All societies.
	Copenhagen and Frederiksberg.	Provincial towns.	Rural districts—Islands.	Rural districts—Jutland.	
	s. d.	s. d.	s. d.	s. d.	s. d.
1893	2 5	2 3	1 8	1 6	2 1
1895	2 5	2 8	2 3	2 9	2 5
1900	2 7	3 2	2 5	2 7	2 8
1905	2 10	3 1	2 7	2 6	2 10
1909	3 0	3 2	2 5	2 4	2 11

B.—Denmark: Average Expenditure per Member in 1909 of Societies which give full Medical Treatment and pay for all ordinary Medicines.

(*a*) Payments to doctors for medical treatment.
(*b*) „ for medicines.
(*c*) „ „ institutional treatment.
(*d*) „ in administrative expenses.

Societies in—	(*a*)	(*b*)	(*c*)	(*d*)
	s. d.	s. d.	s. d.	s. d.
Copenhagen and Frederiksberg	4 3	3 0	1 7	1 10
Provincial towns	5 1	3 2	1 6	1 2
Rural districts—Islands ...	4 6	2 5	0 10	0 5
„ —Jutland ...	4 9	2 4	1 4	0 5
All societies	4 7	2 11	1 3	0 11

C.—Provision of Medical and Surgical Requirements as part of Benefit.

On January 1, 1906, 611 societies supplied all or part of the cost of ordinary medicines, dressings, and the like as part of benefit. The following table shows the percentage of all the societies which granted benefit as shown in the first column—

	Per Cent.
Paid for all ordinary medicines	18·0
„ for from two-thirds to four-fifths of cost ...	4·0
„ for half cost	14·0
„ a small part of cost	7·0
Total	43·0
Did not pay any part of cost	57·0
	100

Number of societies which in 1909 paid for all ordinary medicines in—

Copenhagen and Frederiksberg ...	65	out of a total of	75	societies
Provincial towns	75	„	„	164	„
Island rural districts	81	„	„	559	„
Jutland rural districts	29	„	„	695	„
	250			1,493	

CHAPTER XV

Medical and Surgical Requirements

Conclusions

1. *It is advisable that the provision of medical and surgical requirements, in major part or in whole, should be included in the benefits provided.*

It is usual to provide medical and surgical requirements as part of benefit, in whole or in part. In Germany, their provision is compulsory, within certain limits. In Denmark, it is not compulsory, but a large number of societies, practically all the large societies, do provide them or pay part of the cost.

It necessarily follows from the very object of insurance that drugs, &c., should be granted as part of benefit, when this is financially possible. The primary object of sickness insurance is to afford means whereby the sick person may be cured as speedily as possible. To provide a doctor is good. But his efforts may be wasted if he cannot command the means whereby treatment may be given. To provide a doctor but not medical and surgical requirements is to bring the ailing member within sight of the shore and then to leave him to his own resources—and any others which he may by good chance attract. If he has strength enough—resources enough to buy the necessary drugs, &c.—the help already afforded may be sufficient. But large numbers of the working classes have not. Of course, the patient may come safely ashore on the set of the tide—and often does get back to health without the aid of drugs—but he cannot trust to that in practice.

The resourceless workman may lean on charity for his special needs. But not only is it not safe to rely on charity; to do so strikes at the very root of independence. And the need of medical and surgical requirements, so variable in its incidence, is essentially a risk for insurance.

In this connection, the question of supplying expensive requirements calls for consideration. It will be remembered that under the German law, the societies are not compelled to provide more than ordinary drugs, trusses and similar requirements. They are not bound to supply expensive things—although they may do so if they choose and have the necessary money, and, as we have seen, societies extend, in varying degree, the list of requirements provided. The question whether nourishment and stimulants should be provided is especially important, not because the individual "doses" are costly, but because, if given, they are apt to lead to heavy expenditure. The provisions of the Dresden regulations are interesting in this respect (p. 132).

If a society has adequate resources, it is clearly desirable that expensive requirements should be provided as part of benefit.

(*a*) Their very expensiveness makes it difficult for members to provide them out of their own resources.

(*b*) Being of an exceptional character and the need being uncertain in its incidence—among a group of, say, a hundred normally healthy persons, one might require some expensive medical requirement within two or three years, but it might be quite impossible to tell beforehand who of the hundred would be the unfortunate one—their provision is particularly a fit subject for insurance. In this respect, the provision of expensive requirements is more appropriate for insurance even than that of ordinary requirements.

(*c*) Further, since, comparatively, they would not be often required, the total cost would not be heavy.

On the other hand, if a society has only very limited means, there is much to be said for excluding the provision of expensive requirements.—

(i) The majority of cases require only ordinary drugs, &c., and therefore more good is done, and more satisfaction in general given to members, by providing these.

(ii) It is easier to secure the aid of philanthropy for expensive requirements. Much work is already done by societies in providing, or assisting in the provision of, such needs; and it is important that any new scheme should take full account of prevailing conditions.

As a compromise, where there are sufficient resources, the plan adopted at Leipsic, under which the society pays part of the cost of expensive requirements, is to be commended.

2. *There is much advantage in providing only part of the cost of medical and surgical requirements, especially if there are no other means, such as a deposit system, whereby members have individually to bear part of the cost of benefits.*

Theoretically, no doubt, the provision of all medical and surgical requirements on an insurance basis is the desirable system. But the theoretical gets twisted in practice. The experience of Denmark is most significant. There the societies are small. Control should therefore be easier. Yet the advantages of paying for only part of the cost of medical and surgical requirements have been very marked in the prevention of abuse, and the practice is commended by competent authorities.

It is true that under the German law the societies are required to provide the full cost of ordinary requirements; the new law makes no change in this respect. But the existence of abuse in Germany is admitted.

There are objections which may be raised against such a proposal as that made here, but they are not sufficiently weighty to overcome the real advantages of the plan. They need not be dealt with here, for they have already been considered in treating of the combination of the deposit with the insurance system (p. 92).

3. *Societies should be allowed liberal discretion as to the manner in which medical and surgical requirements shall be provided.*

The question which arises at the outset is whether doctors should be allowed to dispense. In Germany and Denmark, quite apart from the insurance laws, doctors are not allowed to dispense except by special permission. The circumstances in those countries, therefore, cannot be applied to another country with dissimilar conditions without much consideration.

It is urged that, if dispensing were done wholly by pharmacists, there would be less risk of abuse. There would be more publicity. Pharmacists could be more easily supervised and checked than doctors. The risk of collusion between pharmacist and doctor would of course exist, as it does in Germany, but on the whole the danger from this source would not be great. More serious perhaps would be the risk of collusion between pharmacist and patient.

But there is much to be said on the other side also.—

(*a*) In a country where it has hitherto been the general practice for doctors to do their own dispensing, the profits arising to doctors from the supplying of medicines form part of their remuneration. Remove those profits and the already extremely difficult problem of the remuneration of the doctor is made more difficult still.

(*b*) Further, it is obvious that the system could not be introduced throughout a country at once. There would not be sufficient facilities. Incidentally, existing pharmacists would reap an undue advantage.

(*c*) Whereas pharmacists could undoubtedly be more readily checked than doctors, there would be more need of supervision. Among other matters, it would be necessary to secure that the quality of drugs is maintained and that stale drugs are not dispensed, a matter respecting which there may be difficulties in the case of small dealers.

For these and other reasons, in the case of doctors holding salaried appointments, practical administrators, while recognising the objections to the payment of remuneration which includes the provision of necessary drugs, urge that in actual practice it is often better to allow this and to trust to proper supervision of the medical work for the prevention of abuses.

The trend undoubtedly is strongly in the direction of separating medical practice and dispensing. There are reasons for encouraging this tendency. At the same time, in a country where the opposite system prevails, it is well not to move too quickly—in some districts this would be imperative—and to allow societies a liberal measure of freedom in making their arrangements, provided that these are reasonably satisfactory.

A second question which arises is whether societies should be allowed to do their own dispensing, that is, to employ their own qualified men who would do the dispensing required for members of the society.

In Germany there is a growing tendency among the societies themselves to supply those medical and surgical requirements which are not monopolised by the pharmacists. And there is no doubt that the societies would joyfully invade the territory of the pharmacists were they allowed to do so. Where pharmacists have not an established monopoly,[1] there is no reason why, under prevailing conditions, societies should not dispense for themselves if

[1] Or are not organised in a strong corporation of independent practitioners (cp. p. 219); the combination of practitioner and dealer in the pharmacist raises special questions.

the conditions are favourable. Where they are large enough, they may well be encouraged to do so. In a well administered society, it should be possible to do this with gain in economy and efficiency.

One of the principal difficulties in the way would be that the members of a society in a district would be too small to make it worth the while of a society to undertake its own dispensing. Further, the members would object to sending long distances for their medicine. In urban districts, this difficulty could be largely overcome by combinations among the different societies for this particular purpose, the combination employing a dispenser or dispensers for the services of all the affiliated societies. At some places in Germany, the supply of requirements other than those monopolised by pharmacists is arranged through combinations of this kind.

4. *It is essential that there should be systematic control over the prescriptions ordered and the dispensing of the prescriptions.*

The need of control has already been considered at length in the chapter dealing with the conditions in Germany.

With regard to the manner in which the control should be exercised, where societies employ their own dispensers, there would of course be no difficulty. When the societies allow members to obtain drugs, &c., from a number of pharmacists, then, just as with doctors, the societies should welcome the aid of the organisation of the pharmacists, if such exists, and should use it so far as possible for control.

It would be necessary in any case to employ properly qualified persons to act as confidential medical advisers. This matter has already been considered, so far as the doctors are concerned. The services of the confidential medical adviser would be used in connection with the checking of prescriptions made by doctors. Even if the routine work be done by a qualified pharmacist, any

action to be taken should be based on the advice of the confidential medical adviser ; for the doctors would, not unnaturally, object to being checked by a person of lower professional status. Nor would the check of such a person be adequate. For questions would arise—for instance, whether a cheaper drug would not have done when an expensive one had been ordered—which were distinctly medical.

The services of a pharmacist would be necessary in addition for assisting the societies in controlling the pharmacists' part of the work—that prescriptions are properly dispensed ; that drugs, &c., are of good quality ; that there is no collusion ; and so forth. Different societies in a district could combine for this purpose.

5. *Systematic provision should be made for the general education of members respecting the use of medical and surgical requirements.*

In dealing with doctors, the necessity was urged of making provision that members should be systematically educated so that valetudinarianism should be avoided. The experience of Germany and Denmark with regard to the use of medical and surgical requirements drives home the need of similar education in this matter.

The ordinary man (or woman) is only too prone to run for drugs when any little ailment assails him. Not only is this harmful, for the organism would often with advantage right itself without external aid, but, still more important, it engenders in the mind a readiness to fall victim to the smallest ache, to treat minor disturbances as though they were cataclysms, with grievous results. The enormous increase in the consumption of patent medicines is one symptom of valetudinarianism, just as the incessant and insistent advertising of them is at the same time one of the evidences and one of the causes.

It should be realised that the existence of insurance may, without precautions, increase the evil tendency.—

(*a*) If a person feels slightly unwell and the thought crosses his mind that a bottle of medicine would do him good, this thought would probably be only a fleeting notion were it not for the knowledge that the bottle of medicine can be had for nothing; so he takes steps forthwith to get it. And the doctor will generally not refuse it, especially if he has no pecuniary advantage in not prescribing unnecessary drugs.

Undoubtedly some persons refrain from going to the doctor and from obtaining drugs or other requirements when they really need them. But there is no reason why the existence and easy growth of the opposite evil should not be recognised and combated.

(*b*) The member of a sickness society will feel that he has a right to his drugs. He will feel that he has made his payments and should get something back; why not, then, a bottle of medicine? The quotation given in p. 142 from the work of a German doctor is significant.

It is this tendency of the ordinary man or woman to resort too freely to the use of drugs that makes it so advantageous to have some automatic control such as the system favoured of Danish authorities whereby the member himself has to pay part of the cost of the drugs obtained. But even when this practice prevails, and still more where it does not, there is urgent need for the education of members as to the use of drugs, so that they shall not blindly believe in them, just as a native of the African forest believes in the supreme virtue of his charm, but that they shall recognise their limitations, and shall not seek their aid except when the doctor considers that they will be of use. The societies will find that money spent for this purpose will bring a rich return.

CHAPTER XVI

Institutional Benefit

GERMANY

I PROPOSE to deal in this chapter only with the work of the sickness insurance societies. A very large amount of treatment is given by the invalidity insurance authorities, especially sanatorium treatment for tuberculosis. But that treatment is given with preventive intent—to save the funds from being burdened with pensions—and I do not propose to deal with the subject of preventive work in this volume. The subject is a big one and requires lengthy consideration. I shall also make but incidental reference to preventive work done by sickness insurance societies. These societies were not expressly permitted under the old law to expend monies in prevention; but nevertheless some work has been done in this direction. The new law authorises such expenditure.

Legal Provisions

The law provides that, in place of medical and money benefit, a society may give a member treatment in a hospital or similar institution. If the member has persons dependent on him for maintenance, the society must also pay for his dependants money benefit of not less than one-half of the ordinary money benefit, that is, the money benefit payable to him when he is ill and unable to work, and is not given institutional benefit. If the member has not dependants, the society is not bound to pay any money benefit, but may pay an amount not exceeding one-fourth of the ordinary money benefit. Societies are also authorised to allow their

members maintenance at a convalescent home or similar place for not more than one year after the expiration of the ordinary period of benefit.

If a member has a household of his own, or is a member of a household, he is not bound to accept hospital treatment unless he is suffering from infectious disease or from some ailment which cannot be treated properly at home; or unless it is considered necessary that he should be kept under observation (cases where malingering is suspected are brought within this class) or unless he does not comply with the directions of the doctor. Other members have not a right of refusal. Members who refuse hospital treatment and have not expressly the right to do so have not any claim to other benefit.

Members of sickness societies have the same right of appeal as regards inadequate hospital provision, when benefit of this kind is given, as in the case of provision for medical treatment at home. If sufficient members of a society complain to the supervisory authority that the provision is not adequate, it is the duty of the authority to make enquiry in the matter, and, if it finds that the complaint is justified, it may require the society to allow treatment in additional hospitals if there are any available.

The new law, like the old, allows societies to make agreements with one or more particular hospitals for the treatment of patients. But every other public or philanthropic hospital and every hospital maintained by a public association or corporation must be allowed to take patients on the same terms, unless excluded on weighty grounds, with the consent of the supervisory authorities. Doctors complain that the clinics of private doctors are not placed in the same advantageous position. It is of interest to note that the agreement made between the Munich District Society and the Munich Doctors' Association for Free Choice provides not only for the free choice of the domiciliary medical attendant, but also for free choice of institution among those with which the society has an

agreement and are included in the list of the Doctors' Association.

The Practice of Societies

Societies give institutional benefit freely. It forms a large item of expenditure in their accounts.

With regard to money benefit to members with dependants, generally it is confined to the legal minimum of one-half the ordinary money benefit. Many societies pay some money benefit to members undergoing hospital treatment who are without dependants, the amount paid being in some cases very small, a tenth or less of the ordinary benefit.

Another source of difference between societies is with regard to hospital treatment for dependants. As we have seen, many societies give medical benefit to dependants of members. But this may not include full hospital benefit. Societies, however, which give benefit to dependants may pay part of the cost of hospital treatment to them, this payment being intended, apparently, as an equivalent of the medical treatment (with drugs in some cases) which would be provided if the dependant remained at home: thus in a form of agreement prepared by the Cologne municipality for use by sickness societies it is stipulated that the daily payment for a dependant shall be from 3d. to 9d., according to the home medical benefit allowed by the society to dependants of members.

The following are particulars of the benefits given by a few of the large district societies—

Leipsic.—Two-thirds of ordinary money benefit to members undergoing hospital treatment who have dependants; one-fourth (unusually high) to members without dependants; 6d. per person per day paid towards cost of treatment of dependants in hospital.

Munich.—Half ordinary money benefit to members with dependants; one-tenth to members without dependants, subject to certain conditions with regard to length of membership and previous benefit received. Benefit not given to dependants.

Dresden.—Half ordinary money benefit to members with dependants; money benefit not given to members without dependants; 7½d. per person per day paid in respect of dependants receiving hospital treatment.

Kiel.—Half to members with dependants, quarter to members without; 6d. a day for dependants in hospital.

Hospital System in Germany

Some knowledge of the hospital system in Germany is essential to a proper understanding of the work of the societies as regards institutional benefit. The circumstances in Germany are very different from those in this country. The German public authorities, municipalities especially, own and administer hospitals for general purposes, not simply hospitals for infectious diseases.

The hospitals are, as a rule, erected and maintained by the municipality or commune. But in rural districts, the *Kreis*, which corresponds roughly with the English rural district, may participate, by way of contribution, or may even build and maintain the hospital, with contributions from the commune. There are also some "provincial hospitals."[1]

The State Governments differ in their proceedings. In Prussia the State erects and maintains the hospitals of the public universities. It does not contribute towards the cost of local hospitals. In Würtemburg, on the other hand, the State in some cases contributes towards the erection and the maintenance of local hospitals. Philanthropic societies are sometimes assisted by State or local authority in the erection of hospitals.

Patients of all classes are received into the public hospitals, and payment made for all, with the exception of some special cases (*e.g.*, members of the hospital staff). Those who cannot pay for themselves and have not others, such as sickness societies, to pay for them, can generally only be received on payment out of poor law funds.

Each authority makes its own arrangements as regards hospital management. It fixes the classes of patients and the charges in each class. Thus—

Hamburg has four main classes, the ordinary charges for patients in

[1] The province covers a large area. Prussia is divided into provinces (fourteen in all), departments, circles (*Kreise*), and communes.

which are 12s., 7s., 4s., and 2s. 6d. (1s. 6d. for children under ten), respectively, per patient per day.

Cologne has three main classes, with charges of 8s., 5s., and 3s. (children under twelve, 1s. 6d.). But only 2s. a day is charged in respect of members of sickness societies and persons of similar station.

Kiel has two main classes, at 4s. 6d. and 3s. respectively.

Additional payments have generally to be made for special treatment, for instance, X-ray treatment, baths, and the like, and for special requirements, such as trusses. Higher rates of payment are usually charged for persons not residing or working in the town. The higher the class the better the provision made for the patient—accommodation (for example, separate room for first-class patient), attendance, &c.

It is interesting to note that in the Cologne form of agreement previously mentioned, it is provided that the hospital may continue its treatment to a discharged patient as an out-patient on payment by the sickness society of any charges for drugs and dressings, or for special treatment, such as baths or massage.

The sickness societies pay for their patients at the lowest rates, which are the rates for ordinary members of the working classes. These rates are generally much below the actual cost of the hospital service, as will be manifest on comparison of the particulars given above with the following particulars of the average cost of treatment and maintenance per person per day, excluding capital costs, at the towns named—

Hamburg (Eppendorf Hospital)	4s. 2d.
Cologne (Lindenburg Hospital)	3s. 9d.
Kiel	4s. 1d.

The difference between charge and actual cost is not quite so great as would appear from the foregoing figures—

1. The average cost is for all classes. The cost in respect of the upper classes is higher than for the lower.

   This does not make very much difference. Most of the patients treated are in the lowest class. Thus, of the over 700,000 days' maintenance at the Hamburg Eppen-

dorf Hospital in 1910, less than 6 per cent. were in other than the lowest class. Thirty-eight per cent. of all the patients were paid for by sickness societies, and another 28 per cent. by poor law authorities. And likewise at Düsseldorf, over 90 per cent. of the total number of days of maintenance in the municipal sickness institutions was in the lowest class. Of the days of maintenance in the lowest class, over 25 per cent. was at the expense of sickness societies, nearly 3 per cent. at the expense of invalidity insurance and accident insurance authorities, and no less than 61 per cent. at the expense of poor law authorities.

2. The sickness societies pay, in addition to the ordinary rates, some amounts for special services or requirements. But these amounts are probably comparatively small.

Taking full account of all considerations, it is manifest that the sickness societies receive in effect large subsidies from the local authorities in the provision of cheap hospital treatment for their members. And it must be remembered that the costs of treatment and maintenance which have been quoted do not include capital charges.

This form of assistance is not wholly a consequence of insurance. It has been the practice of German municipalities to provide hospital treatment to members of the working classes below cost. But the aid which is thus given to insurance should not be overlooked, otherwise the operation of the insurance system will not be rightly understood.

There has been a very large increase in hospital accommodation in recent years. It has been estimated that, on the average, in 1882, there was one hospital to about every 22,000 persons in Germany; in 1906, one to about every 16,000 persons. There has also been a large increase in the provision of convalescent homes and the like. The sickness insurance has been a principal cause of the increase. And the demand is still for more. In town after town one hears that, despite recent extensions of hospital accommodation, the pressure still continues.

The rates charged by municipalities have been largely increased of late years. Thus at—

Cologne.—The charge was 1s. per person per day until 1894. It was then raised to 1s. 6d., and again in 1907 to 2s. It will probably be raised still higher shortly.

Hamburg.—The charge has been recently raised from 2s. to 2s. 6d. It had formerly been as low as 1s. 2½d.

Düsseldorf.—From 2s. 6d. to 2s. 9d.

Munich.—From 2s. 9½d. to 3s.

Kiel.—The rate was raised to 3s. The district society considered this more than it could afford, and therefore refrained from sending patients to the municipal hospital during 1910, except a few special cases. The consequence was that some members who required hospital treatment did not get it. The number of days of maintenance given at the expense of the society was 20 per cent. less in 1910 than in 1909. Later, the society again decided to send patients to the municipal hospital, partly because it was in a better financial position, partly because other available hospitals had also raised their rates in the meantime—to 2s. 9d., not quite so high as the municipal rate.

The Kiel municipality has in addition a convalescent resort, for use during the day, to which members of the sickness society are sent.[1] There also the charge of maintenance has been raised—from 1s. per person per day to 1s. 3½d.

There are several causes which have contributed to the increase of charges—

1. The general rise in prices.
2. More elaborate treatment, under the advance of medical and surgical science.
3. Higher remuneration to persons employed.

   This has been due partly to the rise in prices. But there has also been a real rise in remuneration. The organised doctors have agitated for and won higher remuneration in hospital as well as in sickness society practice.
4. Increased capital costs.

   The cost of building hospitals has increased alarmingly. Formerly, hospitals were erected at the cost of about £100 a bed, including necessary incidentals; then came a period in which £150 to £300 a bed was

[1] 125 women members were sent to the resort in 1910. The average period of attendance was 18 days. The members received full sickness pay. The extra expense to the society was £126.

usual; now £400 to £500 a bed has been reached.[1] Though much of the increase is probably in large measure unavoidable, it seems to be considered that there is often much unnecessary elaboration, and, as elsewhere, it is stated that it should be possible to differentiate more between chronic and acute cases, and to provide more simply for the former.

5. The drain on the public purse.

The hospitals are a heavy charge on the municipal funds. And the aggregate charge has been increased of recent years, not only by the rise in cost but by the increase of hospital accommodation, an increase which has exceeded the growth of population.

With regard to the staff of the hospitals, in the large urban centres the hospital will be of sufficient size to require the employment of a resident hospital staff. The doctors are generally all paid, except that there may be voluntary assistants who do not receive more than board and lodging. But in small hospitals the doctor apparently may not be in receipt of a salary, but he may be allowed to make a charge for the medical treatment of persons in other than the lowest class. A case was recently mentioned in one of the medical papers in which, not long ago, the doctor was expected to hand over to the local authority part of the money which he made out of the higher classes of patients.

The nursing appears to be below the English standard. There are not so many trained nurses, and the training given is, as a rule, not so thorough. The standard of service generally does not seem to be so high as that provided by the English general voluntary hospitals and by the large poor law infirmaries. An interesting characteristic of the nursing arrangements is that in many cases the municipality does not itself directly employ the nurses but arranges for the provision of nurses with a society, frequently, especially

[1] Pütter: *Finanzielle Erhaltung der Krankenanstalten;* in Grober, *Das Deutsche Krankenhaus*, a monumental work.

in Roman Catholic districts, with one of the confessional societies.

There are numerous hospitals in addition to those of the local authorities—confessional (*e.g.*, Roman Catholic) hospitals; hospitals of philanthropic bodies; &c. There are also in the large towns numerous clinics (or nursing homes) of private doctors; these clinics are licensed by the State.

The charge for treatment at the institutions which are not owned by public authorities is determined largely by the charge at the latter. Generally, the charges at the former appear to be below rather than above those at the latter. If the voluntary hospitals charged higher rates they might not easily get patients. It will be remembered that at Kiel, after the rise of the municipal charges, the sickness society used the voluntary hospitals because their rates were lower, and that afterwards the rates at these hospitals were also raised, but to a lower figure than the municipal one. At Munich also it is stated that the municipality had raised its charges, but that the rates of other hospitals had not been raised.

There are a large number of institutions, some philanthropic, many private, where special treatment is given. Use of these places is made by some of the sickness societies for exceptional cases. The Leipsic society in 1910 sent over 2,400 members to special health resorts, bath establishments, etc.

The particulars given at the close of the chapter respecting the institutional benefit given by the Munich district society will indicate what liberal use may be made of the places available (F). Munich is exceptional in the facilities at its doors, being an important university centre. But most of the large societies allow institutional benefit with a liberal hand. Particulars are also given at the close of the chapter of the institutional benefit granted by the Kiel district society in 1910 (G). That institutional benefit is so much given has a bearing on the remuneration of doctors for domiciliary treatment: the work of the doctors

is reduced by the sending to hospitals and similar places of some difficult and troublesome cases.

Convalescent Homes, &c.

In addition to treatment in hospitals and similar places a large amount of maintenance in convalescent homes is given. Of the 28 district societies of which particulars are given in appendix IX, 11 provided convalescent treatment to their members in case of need.

Some societies have their own convalescent homes. In other cases, a group of societies will combine to provide one. In still others, existing or specially formed philanthropic societies will provide homes for the use mainly of members of sickness societies, or will assist in other ways in obtaining accommodation. Among the most interesting activities of philanthropic bodies in recent years in this direction has been the provision of day convalescent resorts, or forest camps—places out in the country or in forests but within short and easy access of towns, where persons can remain during the day in the open air, returning home at night. The societies make much use of such places when available, paying a price which only covers the cost of maintenance, or even still less. The invalidity insurance authorities also send patients. The use of a resort is not necessarily restricted to the insurance societies and authorities, but in practice these are in the best position to take advantage of them. The societies in such cases pay their members the ordinary money benefit and also the cost of transit to and from the resort.

The societies which own convalescent homes of their own, or have other special facilities for giving convalescent treatment, seem fairly satisfied with the results. But there are misgivings. The cost is often high. There is special danger of malingering. The homes are often delightfully situated, and provide a nice holiday. Strict precautions have to be taken in allowing maintenance at the homes.

Particulars are given at the close of the chapter of the special institutions of some societies (A).

Conditions made by Societies as regards Institutional Treatment

The provisions of the law have already been stated. Societies make in addition special conditions of their own. Doctors are not allowed to send cases to hospitals at their will. The main checks are of two kinds—

1. Generally a case is not allowed to be sent without the consent of the society, except in urgent cases. Doubtful cases may be examined by a confidential medical adviser. An examination of this kind is the general rule, in societies employing a confidential adviser, when special treatment or a stay in a convalescent home is recommended.
2. Many societies prepare returns of the record of each doctor as regards the sending of cases to institutions, and in this way exercise a general control.

Complaint is often made that cases are sent to hospitals by doctors without adequate reason, especially cases which are troublesome or need much attention. The doctors reply, among other things—

1. That it is especially where there is not organised free choice of doctor that hospital abuse occurs. They allege that this happens under the present medical arrangements at Cologne (see appendix IV).
2. That at some places cases may be sent needlessly to hospitals because the doctors who give domiciliary treatment are so inadequately paid that it would be unreasonable to expect them to give elaborate treatment.
3. That often the form of payment does not encourage the treatment of difficult cases at home. When a doctor is paid by salary, or by a capitation fee, or by a fee per case, there is no incentive to give treatment which requires long and laborious attendance. This is not so when he is paid according to the services rendered by him.

The use of hospitals for detecting cases of malingering is important, and great stress is laid on it. The suspected person can be kept under constant observation, and the enforced restraint is irksome. Moreover, although the feeling has been much lessened in recent years, there is still in some places and among some classes strong dislike to being sent to a hospital. That suspected cases of malingering are sent to hospital for observation tends, of course, to perpetuate the dislike.

Expenditure

The sickness societies (excluding the miners') and communal insurance funds spent over £2,250,000 on institutional benefit in the year 1910, being an average of 3s. 6d. per member.

There are considerable differences in the expenditure under this head.—

1. Taking first the different kinds of societies, the expenditure was highest in the contractors' societies (7s. 10d.) and in the guild societies (5s. 5d.). In the establishment societies it averaged 3s. 6d. per member, and in the district societies 3s. 8d. It was 3s. 2d. in the communal insurance funds, the largest group after the district and establishment societies (B).
2. The differences are very great in societies of the same kind. Thus, taking the twenty-eight societies of which particulars are given in appendix X, the average expenditure per member in 1910 was—

over 8s.	in 3 societies
5s. and over, under 8s.	„ 9 „
3s. „ „ „ 5s.	„ 15 „
under 3s.	„ 1 „

The largest expenditure was 8s. 8d., the lowest 2s. 3d.

More striking still is a summary of the expenditure of the several societies which come under the supervision of the Cologne supervisory authority (C). The average expenditure in 1909 was—

(D. District societies.
E. Establishment societies.
G. Guild societies.)

	D.	E.	G.
over 20s.	in —	4	—
10s. and over, under 20s.	„ 1	4	1
5s. „ „ „ 10s.	„ 13	22	4
under 5s.	„ 1	32	1

The average for all the societies was 6s. 2d. It will be seen that the variation was greatest in the establishment societies; no less than four of these paid over 20s., the highest being over 40s.; one society had no expenditure at all on institutional benefit.

The percentage of the total expenditure spent on institutional benefit has increased. In the Leipsic society, the figure was 8 per cent. in 1893, 10 per cent. in 1910. The institutional expenditure forms a much larger percentage in some societies. Thus, at Munich it was 19 per cent. in 1910.

Of course, at some places there are many institutions ready at hand which may be used by insurance societies. The policy of different societies with regard to giving members institutional treatment also differs. And, as previously explained, it is alleged, and no doubt with some justice, that the form of medical service provided and the form and amount of remuneration have an important bearing on the number of cases sent to hospitals by practitioners.

There has been a very large rise in the expenditure on institutional benefit. The average expenditure per member has doubled since 1893. In that year it was 1s. 10d. in all the district societies taken together, in 1910 it was 3s. 8d. (B). In the Leipsic district society, it was 1s. 2d. in 1887; 3s. 9d. in 1910.

Among the reasons for this rise, some of which are the same as those which account for the increase in expenditure on medical service and on medical and surgical requirements, are the following: mention has been made

of some of these when considering the increase in rates charged for hospital treatment.

Benefit has been extended.

It is given for longer periods. Benefits to dependants is given by more societies. There is more use of convalescent homes—an important item of expense (H).

Service is more elaborate, due primarily to the advance of medical and surgical knowledge.

Cost of living and the remuneration paid to officials have risen.

The previously mentioned sources of added expense are reflected in the higher charges made for hospital treatment. The rise in rates has been striking.

There is now more accommodation available in proportion to population, and liberal use is made of it by the societies.

There has been a trend in favour of institutional treatment—a trend manifested most strikingly in the erection of sanatoria for tuberculosis, and shown also in the treatment of other diseases.

A larger proportion of the population lives in urban areas where it is often difficult, especially under German housing conditions, to give satisfactory treatment at home.

The dislike of institutional treatment among the general population is much less pronounced than it was formerly, though it still exists.

This is due partly to the improved service. And, with the numerous and imposing institutions dotted over the country, German thought cannot but become accustomed to institutional treatment, accepting it as a matter of course—sometimes, in a delightfully situated sanatorium or convalescent home, perhaps as a pleasant interlude.

The rise of expenditure affects the municipalities as well as the societies. It represents for them increased capital expenditure on hospitals and increased payments towards upkeep and towards maintenance and treatment of patients. The particulars previously given show that the drain on

the public purse in this respect is very heavy. And to it must be added the drain on the philanthropic purse in providing and maintaining voluntary hospitals and other institutions for treating disease. Clearly a halt may sooner or later have to be called.

A.—The following are Some Instances of Convalescent and other Special Accommodation provided by Societies

Leipsic.—Three convalescent homes were founded by a former president of the society. They are under trust management separate from the society, but, while not restricted to the use of members of the society, are to be primarily at their disposal. In the period 1890 to 1910, over 27,000 members in all were sent to these three convalescent homes. In addition, the society has a convalescent home of its own for men suffering from nervous diseases. A private home is used for similar cases among women. The society has an average of about 250 patients in convalescent homes. The accommodation is to be increased. Persons suffering from lung, mental, or venereal diseases, alcoholics, and persons requiring special attention, are not sent to the convalescent homes.

The Society also has at its disposal a "Zander" Institute. This was given to the society by a doctor. It is equipped with instruments and other means for special exercises which are said to be very beneficial in certain diseases. The institute has a special medical staff. Members and their dependants are treated without charge to them. Connected with the Institute are a Röntgen-ray plant, electric light baths and an operation theatre.

Two day convalescent resorts, one for men, the other for women, are available for members of the society. They are within a short distance of the town, and are owned by a philanthropic society, who allow them to be used by society members at low rates. Patients spend the day there, returning home at night. Patients suffering from pulmonary complaints are sent to these resorts.

Munich.—Two sanatoria, one for men, the other for women. At the former 509 men were treated in 1910 for 34,191 days at an average cost, including capital charges and money benefit, of 5s. 8d. per person per day. At the latter the corresponding figures were—368 women; 21,055 days; 3s. 8d. Some of the patients treated were sent by other insurance societies or authorities.

Hamburg (employees of merchants and tradesmen).—Two convalescent homes, both for women; 1,350 persons received maintenance in 1910 for 32,074 days.

Düsseldorf.—The district societies combined to build a convalescent home. It has 150 beds and cost £42,500, including land, buildings, laying out grounds and roads, machinery, lighting, heating, &c.

Cologne.—A special association was formed, largely at the instance of the chairman of one of the societies, with support from employers, to whom special appeal was made. The association aids financially in providing convalescent treatment for those needing it.

Berlin.—The Central Committee of Sickness Societies has established an institute with baths and massage and gymnastic treatment, &c. There is a special medical staff for the institute. Care is taken to work in harmony with society doctors.

B.—Average Expenditure per Member in the German Sickness Insurance Societies and Communal Insurance Funds on Institutional Benefit

D. District societies.
E. Establishment societies.
C. Contractors' societies.
G. Guild societies.
Cm. Communal insurance funds.
R. Registered voluntary societies.
S. State Registered societies.
T. All the societies and insurance funds.

Year.	D.	E.	C.	G.	Cm.	R.	S.	T.
	s. d.	s. d.	s. d.	s. d.	s. d.	s. d.	s. d.	s. d.
1893	1 10	1 4	5 8	2 7	1 8	1 1	0 10	1 8
1898	2 0	1 8	4 11	2 9	1 10	1 2	1 0	1 10
1903	2 6	2 2	6 11	3 10	2 2	1 5	0 10	2 4
1908	3 5	3 2	7 4	5 0	2 10	1 10	1 8	3 2
1910	3 8	3 6	7 10	5 5	3 2	2 0	1 9	3 6

C.—Cologne: Average Expenditure per Member on Institutional Benefit in the Societies in the Jurisdiction of the Cologne Supervisory Authority

Number of Societies with Expenditure per member as shown in the first column.

	District societies.	Establishment societies.	Guild societies.	All societies.
Over 20s.	—	4	—	4
10s. and over, under 20s. ...	1	4	1	6
7s. „ „ 10s. ...	3	12	2	17
5s. „ „ 7s. ...	10	10	2	22
3s. „ „ 5s. ...	1	19	1	21
Under 3s.	—	13	—	13
Total number of societies	15	62	6	83
Average expenditure per member	6s. 2d.	5s. 9d.	8s. 9d.	6s. 2d.

The highest expenditure was the very high one of 40s. 10d. per member in a building trade society. Another establishment society, in a lead and colour factory, paid 32s. 6d. per member. Some of the establishment societies, on the other hand, paid very small amounts: one had no expenditure at all on institutional benefit.

D.—Leipsic District Sickness Society: Number of Days for which the Following Benefits were given in 1910 to Members

(Number of members, 182,898)

	Days.	Days.
Money benefit (without institutional treatment) ...		1,464,728
Institutional benefit with money benefit	308,634	
Institutional benefit alone	87,184	
		395,818
Total		1,860,546

Hospital benefit was given to—

5,451 male members	for 175,525	days.
2,865 female „	78,428	„
Total ... 8,316 „	253,953	„

E.—Munich District Sickness Society: Expenditure in 1910 on Institutional Benefit

Amounts paid for treatment in—

	£	£
4 municipal hospitals	30,831	
The hospital of the Women's Association of the Red Cross	3,009	
The hospital of the Order of the Knights of St. George, Nymphenburg	846	
Hospitals outside the district	1,239	
The Royal University Women's Clinic	212	
The Royal Surgical Polyclinic	22	
The Royal Gynæcological Polyclinic	11	
The Royal University Eye Clinic	431	
3 eye clinics of private doctors	751	
5 nursing establishments of private doctors ...	808	
Various establishments	29	
		38,189
A homœopathic establishment		94
Asylums	1,138	
Royal Psychiatric Clinic	741	
		1,879
Bath establishments		2,809
Sanatoria and convalescent homes and resorts—		
Society's sanatoria	4,332	
Other establishments	2,960	
		7,292
Inebriate homes		13
Total		£50,276

The expenditure averaged 8s. per member.

F.—Kiel District Sickness Society: Expenditure on Institutional Benefit in 1910

(*a*) Hospitals and other institutions at which cases were treated.
(*b*) Number of cases treated.
(*c*) Number of days of maintenance.
(*d*) Average payment for maintenance and treatment per person per day.

(*a*)	(*b*)	(*c*)	(*d*)
			s. d.
University Hospital...	746	14,796	2 9
Anschar Hospital	78	2,272	2 8
Clinic for mental and nervous diseases ...	99	2,081	2 9
Ear clinic	13	418	2 7
Municipal Hospital	115	327	3 3
Various private hospitals	85	2,700	2 9
Various hospitals outside Kiel	53	1,292	2 10
Through the poor law authorities... ...	39	1,612	2 2
Total	1,228	25,498	2 7

The municipal hospital was used only for some special cases because the charges had been increased. As previously mentioned, one result was that some cases which needed hospital treatment did not receive it. In 1909 the number of days of maintenance in hospitals, &c., was nearly 32,000; in 1910, under 26,000.

G.—Hamburg Sickness Insurance Fund for Domestic Servants [1]

Average membership, 1909, 31,829.

	s.	d.
Benefits paid in 1909, average per member—		
Medical treatment	2	11
Medical and surgical requirements	2	3
Institutional treatment	12	4
Lying-in benefit	0	4
Death benefit	0	3
Contributions in 1909, average per member	20	1

Money benefit is not paid: under the general law employers must continue to pay wages for six weeks to servants taken ill in their service.

Women members needing medical, but not institutional, treatment, who have no place in Hamburg where they can be maintained, are sent by the insurance authority to a philanthropic home—the Martha House. 258 members were maintained there in 1910 for 12,573 days in all.

[1] As previously stated, insurance against sickness has been compulsory for domestic servants in Hamburg under a local law.

Institutional treatment was given for 164,706 days in all.
84,274 days were in public hospitals.
22,140 „ private hospitals, &c.
The hospital treatment was given in 3,674 cases (out of a total of 33,628 in which some form of medical treatment was given). The average length of treatment per case was approximately 29 days.
58,292 „ sanatoria and convalescent homes.

The number of visits paid by doctors to patients at their residences was only 8,472.

The number of consultations at the doctors' surgeries was 82,298.

Institutional treatment for pulmonary tuberculosis was given in 15 cases; in 174 cases treatment was given by the invalidity insurance authority, with contribution from the sickness insurance fund.

H.—The Following Figures, relating to the Operations of the Dresden Sickness Society for 1910, give Some Indications of the Additional Expense incurred by Some Societies in the giving of Convalescent Treatment

	Men.	Women.
Number of patients admitted to the convalescent home of the society during the year	731	916
Total number of days of maintenance	21,689	24,097
	£	£
Total cost of treatment, including capital charges and, in the case of men, money benefit to dependants ...	4,379	3,832
Estimated cost of medical benefit and sickness pay if the persons had been treated at home	2,074	1,309
Excess cost	£2,305	£2,523
Average excess per person (nearest shilling) ...	64s.	56s.
„ „ in 1909 was	77s.	77s.

CHAPTER XVII

Institutional Benefit

DENMARK

Legal Provisions

The law requires recognised societies to provide institutional benefit to their members. It also stipulates that, if treatment in the hospital of a local authority or of the State is granted by recognised societies as part of benefit, the charge to the society shall not exceed half that ordinarily charged to patients of the same class.[1] The Copenhagen municipality allowed treatment to members of insurance societies at much reduced rates even before the insurance law of 1892 was passed.

The law also provides that in rural districts transport to and from a hospital up to a distance of 7½ miles shall be provided at the cost of the commune, in case of need.

Special assistance has been provided for the institutional treatment of cases of tuberculosis under a law passed in 1905. Subsidies may be paid by the State towards the erection of institutions and towards the cost of maintenance. As regards subsidies for erection, it was provided that the total amount to be so expended in the course of the succeeding five years was not to be more than 100,000 kroner (£5,600 approximately) a year, and that the subsidy per bed was not to exceed 1,250 kroner (about £70). Subsidy was not to be paid towards the purchase of land.

The subsidy for maintenance is given on condition that

[1] See note on p. 12. Special payments, additional to the daily rates, may have to be made for some requirements or special treatment.

the rates charged for maintenance shall not exceed certain limits, which range from 1s. 4d. per person per day to 3s. 4d., according to the kind of institution; the rates for children are to be less in certain cases. Subsidy is granted to the extent of three-fourths of these maximum rates for maintenance in the cases of persons who are members of recognised sickness societies, or are of the same station, and of their children.

As in the case of Germany, I do not propose to deal in this volume with the measures taken in Denmark against tuberculosis. Here it must suffice to state that, under the stimulus of the State subsidies, there has been a very large extension of the accommodation provided for tuberculous cases; that practically every person without means who requires institutional treatment for other than advanced tuberculosis may receive it, at the expense of his sickness society if he is insured, or, if there be need, of the poor law; treatment given under the poor law does not carry political disability. In either case, a large part of the cost is borne by the State through the subsidies given. Sickness societies are not obliged to provide sanatorium treatment, but naturally, with the large inducements offered, readily do so.

The law of 1905 was passed in the first instance for five years, at the end of which it was to be reconsidered.[1]

Hospital System

The hospital system of Denmark closely resembles that of Germany. Hospitals are provided by local authorities. The rates charged are usually of two grades, according as the patient is accommodated in a single room for himself or is provided for in the common ward. The charges in the latter class are generally low. They differ in different parts of the country, varying apparently from 1s. 4d. per person per day to 2s. 9d., the more common rates being from 1s. 4d. to 2s. 3d. Children are treated at some places at one-half the ordinary rates.

[1] New legislation has now been passed.

At Copenhagen and Frederiksberg the rates are very low, being but 1s. 4d. the day for an adult. Some allege that the low rates are due partly to the influence of the social democratic party, others deny this. Recognised sickness societies, it must be remembered, only pay one-half the usual charges. The Copenhagen municipality gives still further assistance to members of sickness insurance societies recognised by it. It charges, not only half rates, but also for part only of the time of treatment in prolonged cases. The first thirteen weeks of treatment are at the charge of the patient's society; treatment for the next thirteen weeks, if needed, is allowed free of charge; the society then pays for the succeeding thirteen weeks; and so on alternately until benefit is exhausted. This special concession, like the reduced payment, had been in force before the insurance law was passed. It does not result in so much assistance as might appear. Thus in the largest of the Copenhagen municipal hospitals, in 1909—

127,000 days were paid for, at the reduced rates, mainly in respect of insured patients, but partly in respect of others; only
8,600 days were allowed free under the special concession to insured patients requiring more than thirteen weeks' treatment.

The proportion of free days was therefore small, due, of course, to the fact that the majority of cases terminate before the first thirteen weeks are ended.

Apart from this special concession granted at Copenhagen, it will be seen that the local authorities—and the State—give the sickness societies a double subsidy in respect of hospital treatment—

(*a*) The ordinary charges for persons treated in the general wards appear to be usually considerably below cost price.

(*b*) The charge to the societies is only one-half the ordinary rate. Some authorities give an abatement of even more than one-half.

How large the subsidy is in some instances will appear from the circumstances at Copenhagen.[1] The average cost of maintenance and treatment, excluding capital

[1] But the charges at Copenhagen are exceptionally low.

charges, at the largest of the Copenhagen municipal hospitals was over 4s. 9d. per person per day in 1909–10. The societies paid only 8d. a day for adults, 4d. a day for children. The assistance, therefore, is at an exceedingly high rate.

There is at Copenhagen, in addition to the municipal hospital, a large State hospital—the *Rigshospitallet*. It has recently been rebuilt and will have an accommodation of nearly 1,000 beds (including a large lying-in department, with 183 beds for mothers and 100 for infants, which is an old foundation founded by a Queen of long ago who seems to have had an overflowing sympathy with the unmarried mother). Persons are received into this hospital from the provinces as well as from the capital district, provided that the case is of sufficient medical interest. The charge made for treatment is the same as that made by the authority of the locality in which the patient resides for treatment in its own hospital. The capital cost and the cost of maintenance at the hospital are very high, partly because it is the medical school of the university.

The stimulus given to insurance against sickness by the insurance law of 1892 has in turn markedly stimulated the provision of hospital accommodation, especially in the rural districts. The kingdom is now fairly well supplied with hospitals.

But, despite the large extension, the pressure on hospital accommodation is still severe. Thus at Copenhagen, the *Rigshospitallet*, as recently rebuilt, has much increased accommodation. The municipality, which has already made large hospital provision (see B at close of chapter), is building a new hospital for 500 beds. But I was given to understand that the provision of twice this number of beds or more would not exceed the demand.

The reasons for this largely increased demand for hospital accommodation are similar to those which apply in

Germany. I was informed at one of the large hospitals that one important cause was the treatment at the hospitals of chronic cases, many of which could well be dealt with in much less elaborate institutions. There appears to be little dislike of hospital treatment among the working classes; among some sections, in fact, there seems to be a decided liking for it, especially in a new hospital. I was told by an official of one of the societies that, after the opening of the new *Rigs* hospital, so great was the request for treatment there among sick members of the society that a special form was printed to meet the occasion.

There are hospitals in addition to those of the public authorities, more particularly hospitals run by religious denominations. There are several sanatoria and similar places administered by philanthropic societies. But the bulk of the hospital accommodation appears to be in the institutions of public authorities.

Practice of Societies

As will be gathered from what has already been said, hospital benefit is freely given by the societies. The law offers a large inducement in the way of half charges; and this inducement is reinforced by the low rates fixed at many places, especially at Copenhagen and Frederiksberg, which together include about a fifth of the population of the whole kingdom. So freely is hospital benefit given in Copenhagen that even the doctors sometimes complain, saying that they are being turned into mere visitors for the hospitals or restricted to cases requiring specialist treatment which can be given outside the hospital.

As regards rural societies, while there has been a large extension of hospital provision since the passing of the insurance law, in many districts the population is too scattered to make hospital treatment readily practicable.

The societies being small in size, they do not provide institutions of their own. Nor are institutions provided through the federations. The societies rely on those founded by the State and local authorities and by philanthropic bodies.[1]

Expenditure

Nearly £39,000 in all was spent by the societies in hospital benefit in 1909, exclusive of a small amount obtained from re-insurance groups for tuberculosis treatment. The £39,000 was 10 per cent. of the total expenditure, and averaged 1s. 3d. per member. Of the total—

£	
33,000	was expended on hospital treatment
5,400	„ „ sanatorium treatment
600	„ „ asylum treatment

There has been a remarkable increase in the expenditure on institutional benefit (A). The increase has been large in the capital district. It has been still more marked in the provincial towns and in rural districts. This will be manifest from the following figures of the average expenditure per member in societies in the different localities in 1895 and 1909—

Societies in	1895 s. d.	1909 s. d.
Copenhagen and Frederiksberg	1 0	1 7
Provincial towns	0 9	1 6
Rural districts—Islands	0 4	0 10
—Jutland	0 4	1 4
Whole country	0 7	1 3

With regard to the reasons for these increases, what has been said of Germany might largely be repeated here. The principal causes are said to be the largely increased provision of institutions, and the steady waning of the dislike of entering them. It will be noticed also that the amount expended in 1895 was comparatively small, so that there was ample room for expansion. But

[1] The payment of money benefit when a member is in an institution is optional, except that not less than 30 öre a day must be paid in the case of a married man.

it must be borne in mind that, because of the low rates charged, the amounts expended by the societies was only a small part of the total cost of the institutional treatment given. The largely increased provision of institutions for the treatment of tuberculosis has also been an important factor in increasing the amount of institutional treatment.

Not only the absolute amount but also the proportion of the total expenditure spent on institutional treatment has increased of recent years. Thus, during the years 1894–9 it formed 6·2 per cent. of the total; during the years 1901–6, 8·7 per cent.

The lower amounts spent by the Danish than by the German societies do not indicate less proportionate institutional benefit. In comparing the two, account has to be taken of the different rates of charges. Thus, comparing Hamburg and Copenhagen—at the former place societies have to pay 2s. 6d. a day for the treatment of an adult member in one of the municipal hospitals, the actual cost of treatment, exclusive of capital charges, being about 4s. 2d.; at Copenhagen, a society has to pay but 8d. per day and the actual average cost is about 4s. 9d. As previously stated, the figures 4s. 2d. and 4s. 9d. cover costs for persons of the higher classes as well as those for patients of the class of insured persons, and would have to be reduced some little to get at the cost for the latter alone: capital costs are excluded. Roughly, it may be said that, in the case of the Hamburg society and hospital, about two-thirds would need to be added to the payments made by the society to arrive at the actual cost of hospital benefit; in the case of Copenhagen, on the other hand, the expenditure by a society would have to be multiplied several times, after allowing for any extra payments in addition to the daily rates.

[1] In comparing public assistance in Germany and Denmark towards institutional treatment, account should be taken of the treatment of this kind given by poor law authorities. Some particulars of provision afforded through the poor law are given in p. 167 respecting Hamburg and Düsseldorf, and p. 188 respecting Copenhagen.

It is manifest that the very large subsidies which are in effect paid by the local and central authorities towards hospital treatment of insured persons play a large part in Danish insurance. In Denmark as in Germany, the provision of hospital treatment for members of the working classes at rates much below cost is part of the general activity of the local and central authorities. But in Denmark, in addition, there is the special privilege of treatment at half rates, and in both countries hospital treatment would not have developed to nearly its present extent had it not been for the spread of insurance.

In Appendix X some particulars are given respecting the expenditure of sixty-six Copenhagen societies on institutional benefit. The average expenditure per member of these sixty-six societies in 1910 was 1s. 8d. Most of the societies expended between one and two kroner per member. (A krone is roughly equivalent to 1s. 1⅓d.). But ten societies spent larger sums.

An instructive table (B) is given at the close of the chapter which shows the number of days of maintenance for the different classes of patients in the municipal hospitals of Copenhagen in the year 1909–10. It will be seen that one of the five hospitals for which particulars are given was used mainly for infectious diseases, and nearly all the patients there were treated at the public expense; 540,000 days of maintenance was given in all at the other four hospitals. Of this total—

only 16 per cent. was paid for at the full rates, and it must be remembered that these rates, for patients in the lower class, are much below cost;

over 40 per cent. was at reduced rates for members of sickness societies;

the remaining 44 per cent. was given free of charge,

between 4 and 5 per cent. being for members of sickness societies for whose treatment and maintenance payment had been made by their societies for the thirteen weeks preceding the free period; and

27 per cent. being at the charge of the poor law.

It will be manifest from these particulars that at Copenhagen much the larger part of the cost of hospital treatment in the municipal institutions is borne by the community. Very few patients, comparatively, pay in full for their treatment and maintenance. In the year 1909, the expenditure and income of the largest of the municipal hospitals of Copenhagen were—

	£
Expenditure	96,793
Income	20,751
Excess Expenditure	76,042

At one of the hospitals, patients suffering from tuberculosis are treated and the State pays subsidy in respect of these patients in accordance with the law to which reference has been previously made. The municipality, in addition, possesses a sanatorium, and the State subsidy is paid in respect of the patients there also.

A.—Average Expenditure per Member of Societies for Institutional Treatment, including Treatment in Sanatoria and Asylums

Year.	Societies in—				All societies.
	Copenhagen and Frederiksberg.	Provincial towns.	Rural districts.		
			Islands.	Jutland.	
	s. d.	s. d.	s. d.	s. d.	s. d.
1893	1 1	0 5	0 2	0 3	0 6
1895	1 0	0 9	0 4	0 4	0 7
1900	1 2	1 0	0 5	0 7	0 9
1905	1 8	1 4	0 8	0 11	1 1
1909	1 7	1 6	0 10	1 4	1 3

B.—Copenhagen Municipal Hospitals: Number of Days of Maintenance of the Different Classes of Patients during the Year 1909–10

	Hospital.					
	Kommune.	Oresunds.[1]	Sundby.	Balders.	Total of preceding four.	Blegdams.[2]
	Days.	Days.	Days.	Days.	Days.	Days.
1. With payment,						
(*a*) full payment ...	64,204	13,231	4,096	3,507	85,038	3,045
(*b*) reduced payment (members of sickness societies recognised by State or municipality) ...	127,416	58,166	16,971	17,020	219,573	3,612
	191,620	71,397	21,067	20,527	304,611	6,657
2. Free treatment in accordance with municipal regulations,						
(*a*) members of recognised sickness societies	8,623	13,041	1,932	747	24,343	39
(*b*) other persons ...	3,066	993	152	286	4,497	1,731
	11,689	14,034	2,084	1,033	28,840	1,770
3. Free treatment on account of old age (law of April 9, 1891)	9,221	1,922	946	1,251	13,340	70
4. Charged to poor law department	75,814	59,174	6,585	4,135	145,708	3,304
5. Treated for infectious diseases (public health laws)	3,695	5,107	—	—	8,802	133,209
6. Free treatment under law of March 30, 1906 (venereal diseases) ...	41,120	62	—	—	41,182	—
Total	333,159	151,696	30,682	26,946	542,483	145,010

See Notes on opposite page.

There is another municipal hospital (Vestre Hospital) in which free treatment is given under the law of March 30, 1906, for venereal diseases. 41,290 days of maintenance were given in this hospital in 1909–10.

---

[1] One department of this hospital is for tuberculous patients. 63,993 out of the total 151,696 days of maintenance were in this department. Subsidy was received from the State in respect of 62,792 (55,969 for adults, 6,823 for children) of the 63,993 days.

[2] It will be seen from the figures that this hospital is mainly used for infectious cases.

CHAPTER XVIII

Institutional Benefit

Conclusions

1. *The provision of institutional benefit is essential for adequate medical treatment.*

It is obviously necessary that there should be some institutional provision for the proper treatment of disease. Certain kinds of serious operations, ailments which require constant skilled attention—these cannot be well treated at the homes of persons of the working classes.

This is fully realised in Germany and Denmark, and large provision is consequently made for hospital treatment, which is given under very favourable terms, especially in Denmark.

The housing conditions of to-day make the need of hospital provision more acute. A large proportion of the population lives in urban areas. Rooms are often small, and there is unavoidable lack of facilities for home treatment, sometimes even of comparatively slight ailments, much more so of serious ones. At the same time, medical treatment tends to become more elaborate in some respects.

Need of hospital provision is acutely realised even where insurance does not prevail on a large scale. In all modern communities the establishment of hospitals almost inevitably follows in the wake of the growth of towns, hospitals where persons of small means are treated without cost to them, or at a low charge.

Whether it is necessary that hospitals and similar institutions should be provided so largely as in Germany

and Denmark, whether they cannot be kept within narrower compass without general detriment, are questions to be considered in a later section.

2. *It is not practicable for workmen to provide adequate institutional benefit through their own societies without a liberal measure of assistance.*

Both in Germany and in Denmark a large amount of assistance is given expressly for institutional benefit, over and above general assistance given to insurance. In Germany the societies appear to be charged only from about one-half to about three-fourths of the actual cost of hospital treatment, even excluding capital charges, while in Denmark the amount is very much smaller still, especially so in the case of Copenhagen. There is not evidence that the assistance is superfluous, though it may be excessive in some cases.

The difficulty lies, of course, in the cost of hospital treatment, which comes to from about 3s. to 5s. per patient per day, excluding capital charges. Payment at these rates would quickly drain the funds of a society if indulged in to any large extent, especially if payment of money benefit to the dependants of a member were added to them. Even as it is, the cost of institutional benefit is very high in the German societies. Workers in the higher ranks of industry might be able to provide for necessary institutional treatment on an insurance basis without assistance. But clearly it is beyond the means of the lower ranks, and, while the aim of every group of workers should be to secure remuneration for their labour sufficient to enable them to provide for their requirements independently, that goal has not yet been reached.

Undoubtedly there is some room for more economy in hospital treatment both in Germany and Denmark. There appears to be a widespread feeling that expenditure is needlessly high. But however strict an eye be be kept on costs, the expense will still be heavy. Medical

treatment is constantly acquiring new elaborations, and experts do not court economy. One of the principal ways in which money may be saved is in differentiating more clearly between the acute and the chronic cases, and in providing simpler accommodation and service for the latter. But this would not help the sickness societies much, for their members would generally be in the acute class. But the societies would gain to some extent by the general reduction in hospital costs. They stand to gain most, however, by not sending cases to hospitals unless it is clear that such treatment is essential.

3. *It is not advisable that assistance should be given expressly for hospital treatment.*

While recognising that persons of the working classes must be assisted for the provision of hospital treatment, it does not follow that the assistance need be given expressly for that purpose. It may simply be taken into account in fixing the amount of assistance to be given to insurance generally. And there are reasons why this is the preferable course.

It is true that in both Germany and Denmark assistance is given expressly towards hospital treatment. In the latter, this is definitely provided in the law. In the former, the authorities provide hospital treatment at much below cost without express legal provision.

But neither in Germany nor in Denmark can it be said that the conditions are satisfactory. In both countries there appears to be much hospital abuse. This is due partly to the form and amount of remuneration paid to medical practitioners, partly to want of adequate control. But it is fostered by the comparatively low rates charged, which make the societies less inclined to be strict. This is especially the case in Denmark, and doctors frequently complain. Complaints from the doctors are also heard in Germany, though the charges there are much higher.

There are several reasons why it is inadvisable to encourage hospital treatment by giving assistance expressly allocated to it.—

(*a*) It is wasteful to the community.

If cases are sent to hospitals which might well be treated at home, there is a great deal of social waste, because of the much higher cost.

(*b*) It is injurious to the interests of the doctors.

The more spent on hospitals and treatment in them, the less is there left for the outside practitioner. And although doctors are necessary in hospitals, much of the work is done by assistants; and too much has to be spent on other expenses to leave room for large salaries to many doctors.

Moreover, if cases are sent too freely to hospitals, there is danger that the efficiency of doctors outside will deteriorate. If difficult or troublesome cases can be and are readily sent for institutional treatment, doctors may lose skill, not only for treatment of serious ailments, but also for ordinary ills, and a general slackness may creep in. It is alleged that this sometimes happens in Germany. Further, the man who is undergoing training is likely to limit his acquirements according to the demands which will be made for them.

(*c*) The gain even to a sickness society of reduced charges may be dubious.

The cheap is not always the economical, in more ways than one. The reduced rates may encourage too free use, cases being sent which could well be treated at home. And it must not be forgotten that insured persons, as members of the general community, whether ratepayers or not, will themselves probably have to bear no small part of the assistance which is given to themselves by municipality or state.

(*d*) Home treatment has important incidental advantages of its own.

An illness in a family may be the best opportunity for teaching valuable lessons in hygiene, resulting in raising all the members ultimately to a higher standard of health. This is especially so if there is a good system of district nursing. This gain is lost if a patient is packed off to an institution.

No doubt there are incidental gains when the patient is sent to an institution. More especially, there is less strain on the mother, and she is better able to look after the family, a matter of supreme importance where there are young children.

But life is complex. It does not pay in the long run to make things too easy. To shelter persons too much from stress is to breed weakness. There may be invaluable gain to character, not only for the wife but for the children also, by being brought into grips with difficulties. The main safeguard needed is to prevent the strain from becoming too great; not to remove it altogether.

(*e*) To the patient, also, treatment at home has its advantages.

Some have already been mentioned. There are others. He may prefer home treatment. The dislike of the hospital, though it is much less than formerly, still exists. His family may be better off. While he is ill and at home, he receives full money benefit. Removed to a hospital, his family will only receive reduced money benefit, if any at all: the society generally cannot afford to be very liberal, having regard to the cost of hospital treatment.

Insistence on home treatment, where practicable, may have an incidental bearing on housing. Liberal provision of hospital accommodation may play some part in reducing the incentive to better housing, a part doubtless small in itself; but if all the various exceptional uses for which a house or apart-

ments may be required are removed, the sum total of the incentive to spacious housing will be much lessened.

(*f*) There is no reason why societies, if large enough, should not be encouraged to provide their own hospitals and other institutions.

On the contrary, there may be gain where they do so, either singly or in combination. They are thus brought into closer touch with the facts of disease. Having themselves to find the money they will probably be economical, perhaps on occasion too economical. Since the members would be providing institutions for themselves through their own societies, the institutions and their management would very likely be more suited to the real needs of members. There would not improbably be less coddling, or shall we say weak humanitarianism, than if managed by members of another class. But there need not be less efficiency. Workmen are not given to expending decorative sympathy on each others ills.

But if municipalities or the state provide treatment at hospitals of their own at greatly reduced charges, societies will obviously not readily provide similar institutions wholly at their own cost.

4. *Special precautions are necessary to restrict institutional benefit within reasonable limits.*

The need for not indulging too freely in institutional treatment will have been obvious from what has already been written. Abuses quickly crop up if special precautions are not taken. This is manifest from the experience of Germany and Denmark.

Allegations are made that doctors send troublesome cases too readily to hospitals. On the opposite side, complaints are sometimes made by doctors that the societies use institutions too freely, and that, especially in the case of serious operations, for instance, for which

doctors would be allowed to make special charges, the latter have to compete with institutions liberally subsidised by state, municipality or other local authority or philanthropy.

The very existence of a large amount of hospital accommodation tends to breed abuses. It is a truism that the demands for admission grow with the number of places available. And the competition of voluntary and municipal or state institutions may also play an important part. For to show economy of service and, in the case of voluntary hospitals, to make a strong case for liberal support, it is necessary that an institution be well patronised, and something may result that comes very near to bidding for patients.

There are several kinds of precautions which may usefully be taken. One is mentioned in the next section. Strict control should be exercised over the sending of cases to hospitals. It will not be practicable or advisable to have each case examined by a confidential medical adviser, but doubtful cases should be referred to him, and he might examine other occasional cases for check. The record of each doctor should be periodically and systematically scrutinized so that action might be taken against any practitioner who is lax. The conditions of treatment in the hospital, while providing all that is essential and conducive to cure, should not be so attractive as to encourage persons to seek hospital treatment without due cause. And arrangements should be made to guarantee good treatment at home, with nursing care if needed.

5. *Medical practitioners should be remunerated in such a manner that they have not any pecuniary inducement to send cases unnecessarily to hospitals.*

This question has already been fully considered (see especially pp. 89–90), and is repeated here because of its importance. In chapter IX, p. 90, a way is suggested by which the interests of the doctors and of the societies, in the matter of remuneration, may be reconciled.

6. *The provision of an adequate system of home nursing is desirable. This has the incidental advantage of reducing any tendency to hospital abuse.*

In Germany, a large amount of district nursing is done through philanthropic and religious bodies. And the invalidity insurance authorities make grants in aid of work of this kind. But there appears to be an absence of systematic provision for home nursing on the part of the sickness insurance societies.[1] This is probably one reason why there is such a run on hospitals. The new law provides that in certain cases an insured person, with his consent, may be provided with nursing care at his home instead of being sent to a hospital.

In Denmark also, the employment of district nurses seems common, but they are not employed directly by the sickness societies, except in the case of a few rural societies. Many societies, however, subscribe to the funds of nursing associations,[2] and obtain in return a preferential claim on the services of the district nurses. An interesting experiment is being made in Frederiksberg. The municipality is employing nurses to attend at home some cases of insured patients who would otherwise be sent to the hospital. If the experiment succeeds, other towns will undoubtedly follow suit. The plan would be much cheaper to the municipalities than if the cases were sent to their hospitals.

The experience in this country is itself sufficient testimony to the value of providing a good system of district nursing. The employment of nurses of this kind has extended very rapidly in recent years, and excellent work is being done by them.

It will pay sickness societies to encourage the attend-

[1] In the report of the Leipsic society for 1911, mention is made of payments for the services of communal nurses to members and dependants.

[2] It is interesting to note that there are associations in Denmark which provide nursing attendance in return for periodical contributions. The State pays a subsidy to the associations.

ance on patients at their own homes by qualified nurses. There are several ways in which they will gain; thus—

Provision of home nursing will make it possible to deal with cases which would otherwise have to be sent to institutions.

The wife, or mother, can be provided with just that modest amount of skilled assistance which she may need to prevent the strain upon her from becoming too great.

Cases can be cured more quickly. The nurse can see that the medical directions are carried out, and proper measures taken for the good of the patient, especially in small matters which the doctor generally has neither time nor patience to see.

Not least important, the district nurse may be the most effective of the missionaries of hygiene. She comes into closer touch with the people than the doctor. She often understands them better, knows better their needs and difficulties, especially if, as is often the case, she comes of the same social class.

It will be seen, therefore, that there are strong reasons why sickness societies should take up energetically the provision of district nursing, either by directly employing nurses or by entering into agreement with associations for the services of nurses employed by them.

7. *The provision of maintenance in convalescent homes should be kept within narrow limits.*

The advantage of convalescent homes is of course that, under the favourable conditions prevailing in them, a person may speed quickly to full health, whereas otherwise he might only slowly crawl to recovery. Most societies in Germany do not provide convalescent treatment, but there has been a decided trend in favour of it in the large societies.

But there are attendant disadvantages. The cost is often heavy to a society. Every patient may think that

he too needs a stay in a convalescent home when he finds that his fellow-member receives it. The experience of Germany shows the need of special precautions. Some societies only give convalescent treatment to cases passed by their confidential medical adviser. But if the benefit is provided on a large scale, even he would probably not be able to keep out all unsuitable cases. It is an effective safeguard when the number of places is so few that there must be strict selection.

After all, it is only a very small proportion of cases which cannot thrive quite well to health without being sent to a special home, especially if they can be induced to follow closely the rules of health. And this convalescent period is an excellent time for inculcating hygienic habits, which cannot be learnt nearly so effectively in the automatic discipline of an institution as when they have to be self-imposed in the every-day surroundings of home life.

Nor is a collection of convalescents, probably spending much time in talking about their own diseases and symptoms, a good place for banishing ills. There is danger that the convalescents will become valetudinarians. For this reason alone the value of a stay in a convalescent home is often open to serious doubts. Further, while the well-to-do can indulge in the luxury of going away to recruit returning health, the workman can but rarely afford to do so, either when he has to pay for it himself, or when the expense to him is masked by its being paid through his insurance society.

8. *Societies should be allowed to make their own conditions as to the acceptance of hospital treatment by members, with forfeit of other benefits if they refuse.*

In Germany, the member is given a large right of refusal. If he has a household of his own or is a member of a household, he can practically only be required to accept hospital treatment (*a*) if it is clear that he cannot be properly treated at home, (*b*) if he is not following

the directions of the doctor or is suspected of malingering. But the decision of the question whether a member can be properly treated at home leaves the society a wide discretion. This discretion, however, is largely curtailed because the member has a right of appeal to the supervisory authorities, in case of refusal of benefit, and that authority therefore sets the standard.

In Denmark, societies make their own rules and fix their own conditions. But there is appeal to the State inspector in case of dispute.

A policy of giving the societies full discretion to make their own arrangements seems the most expedient—

(*a*) The necessity of intervention by the authorities may lead to friction, and reduce the influence of the authorities with the societies. This influence, discreetly used for guidance, may well be much more important than any direct control.

(*b*) Intervention weakens the authority of the society, and the society needs all the strength that it can get, moral and material, to deal with the difficult problems in its path. The spirit of comradeship and solidarity should be encouraged. It is not good to cultivate among the members a habit of running to the supervising authorities when they have a grievance. Efficiency is also thus reduced. The society is likely to be in a much healthier state and to thrive better if dissatisfied members have to persuade their fellows of the justice of these grievances, and have not ready means of calling in the strong arm of superior authority.

(*c*) The practical difficulties of fixing clear standards when and when not a person is justified in refusing hospital treatment are great. The question must often be decided to a large extent arbitrarily. It depends upon conditions difficult to assess—the condition of the home and the circumstances of the patient and his family ; the skill, attention, and means at the disposal, of the doctor ; the facilities

for nursing ; &c. It is true that these difficulties face the societies as well as a supervisory authority. But the societies will probably be more intimate with the prevailing conditions ; moreover, a supervisory authority, acting in a judicial capacity, should generally be expected to act only on clear, definite rules and information.

(*d*) Freedom of control to societies in this, and in many other matters, is a necessary corollary of freedom of organisation. If a member is dissatisfied with the action of his society, he has his own remedy ; he can leave it. True he may lose some little by so doing. But he must stand the risk. And the society would be under a corresponding risk. The liability to lose members if they are not treated fairly is the best safeguard of justice.

In Germany there is not freedom of organisation. As a rule, a member has no say in determining to what society he will belong. Membership automatically follows on employment. There is therefore special reason why his right of benefit should be safeguarded by right of appeal, since he cannot withdraw his membership.

CHAPTER XIX

Insurance and Public Health Authorities

The work of the insurance and of the public health authorities is obviously very closely connected. Both deal with disease. The efforts of the public health authority are mainly directed to its prevention, but, as incidental to prevention, a large amount of treatment is undertaken. The sickness insurance authorities are chiefly concerned with sickness, but, as already indicated, the preventive side of their work has to be pushed if their labours are not to lose much of their value. In Germany the societies are realising this more and more.

Both in Germany and in Denmark, the public authorities give treatment for certain infectious diseases free of charge as a measure of public health. I was told that in Denmark disputes sometimes arise between the public authorities and the insurance societies, because the former endeavour to extract payment from the latter for cases which the societies consider should be treated free of charge.

Even if the dividing line between infectious diseases and others were clearer than it is, this alone would not suffice as a means of separating the functions of the insurance and the public health authorities. The class "infectious diseases" is constantly being extended. The most marked recent instance is tuberculosis.

In Denmark, it will be remembered, the State has contributed very liberally to the erection of tuberculosis sanatoria and hospitals, and to the maintenance of patients. This has been taken more as a public health measure than as assistance to insurance. For the subsidy is paid, not only in respect of insured persons and their children, but

for all persons of similar station, whether insured or not—is applied, that is, to the population in general.

In Germany institutional treatment for tuberculosis has hitherto been given mainly by the invalidity insurance authorities as part of their ordinary work. But more and more, in accordance with the general trend in all Western countries, the necessity of extending treatment to persons who are not insured is being emphasised. And the dispensary movement, which has made very rapid strides in Germany, has introduced a new phase. The dispensaries are generally run by philanthropic societies. Insurance bodies and public authorities contribute to their support. The dispensaries as a rule minister to the needs of the population in general, not simply to the insured.

In considering the relations of public health and insurance authorities, it is also of importance that the work of the former, while especially concerned with infectious disease, extends to health and disease generally. It is their business, within certain limits, to see that conditions injurious to health in general are removed and replaced by others which will conduce to a higher standard. In this work they come unavoidably into close touch with the insurance authorities.

There seems to be room for a fruitful development which does not yet appear to have taken place to any marked extent in either Germany or Denmark. As previously stated, the sickness experience of the insurance authorities, if properly analysed, should provide a firm foundation for action, not only by the insurance groups, but also by the public health authorities. Above all, the information, rightly used and made popular, should provide means of developing an informed public opinion, which is of cardinal importance in a democratic community, both for insurance and for public health. The public health authorities, with their trained experts, can assist in analysing and in extracting the lessons of the records of the sickness insurance groups in their districts.

In Germany in recent years, as in other countries some

steps have been taken for the treatment of school children. Clinics have been established at some places, at which school children are treated free of charge or at a low rate. In Denmark, the question of treatment does not seriously arise, and the school doctor can be kept to inspection and consultation, because of the provision in the law that the insurance of the parent automatically carries medical treatment for his children up to fifteen years of age living with, and dependent on, him.

On the continent, the relations between the insurance groups and the public authorities are further complicated by the fact that the latter maintain hospitals for the treatment, not only of infectious diseases, but of ailments in general which need such provision. This function is undertaken, not as a measure of public health, but as part of the general business of the local authority. Charges are made for treatment. But it is important to remember that the charges made for persons of the working classes are generally much below the cost of treatment and maintenance.

One interesting, though not very important, point of connection between public health and insurance authorities in Germany has been the appointment in recent years in many districts of the *Kreisarzt*—the medical officer of health of rural and the smaller urban districts—as confidential medical adviser of the local invalidity insurance bodies. This step does not appear to have been taken with intent to form a connection between the public health and insurance authorities, but because it was felt that it was necessary to make better provision for the examination of persons claiming invalidity pensions, and the *Kreisarzt* was conveniently placed for assisting the local insurance bodies in their work.

In some ways the public health authorities seem to be in a favourable position for assisting in the local supervision of insurance. They are, or should be, conversant with local conditions, and have at their disposal experts

trained in judgment of matters of health and disease. In Germany, the local authorities are used for supervision—but not as public health authorities, though the medical officers are available for advice. The supervision is general—to see that the requirements of the law are fulfilled, and to decide judicially on complaints. The relations between the public authorities and the sickness insurance societies have been largely affected by two facts—(1) that it was the intention of the law to give the societies a very free hand, leaving administration almost wholly to the contributors towards insurance; (2) that the public authorities do not generally contribute *directly* to the insurance funds: there is therefore the smaller lever and the less reason for control. And as regards the invalidity insurance authorities, they soar much too high on their wide-spreading wings to be supervised by the local authorities.

In Denmark, owing to the comparatively small area and population, there is less need for local supervision: the central department can keep its eye on the proceedings of the societies. Further, the law is based on the principle of a wide and generous autonomy to the societies. But obviously this need not be any bar to close co-operation between the societies and the local authorities.

If it is so important as it seems that the public health and the insurance authorities should work together, if they should supplement and complement the work of each other to so large an extent, it needs to be explained why there is not more systematic co-operation in Germany and Denmark—in Germany especially, where insurance has so permeated social life, and where the laws have recently been elaborately revised after prolonged consideration. There are a number of reasons for the existing conditions, besides those which have already been mentioned.

(*a*) The public health service was not highly developed when compulsory insurance was first established by the Imperial Government.

The insistence on sanitary administration, especially

the appointment of expert medical men expressly for the work is of recent date in Germany and Denmark no less than in other countries. There are still districts without a medical officer of health.

(*b*) The attention of the insurance authorities was at first directed almost wholly to cure, so far as dealing with disease was concerned.

In sickness insurance no attention, or very little, was given to prevention, and it is in the work of prevention that insurance and public health work touch most closely. The law did not contemplate that any part of the funds of the societies should be expended in preventive work. And in invalidity insurance, in which prevention has now grown to such large dimensions in Germany, the provision of pensions was almost exclusively the work undertaken in the beginning. Little money was spent on preventive work until well on in the 'nineties. And it has to be borne in mind that the invalidity insurance did not come into being until about half a dozen years after compulsory sickness insurance had been established.

(*c*) The work of public health was at first directed chiefly to material things.

Ventilation, drainage, disposal of sewage and garbage—it was with matters of this kind that the public health service was mainly concerned at first. The "Inspector of Nuisances" is the pope of the period. The work of personal hygiene, with which public health is dealing more and more, is of recent growth.

(*d*) The measures of prevention adopted by insurance authorities in the beginning dealt with individuals in contrast to measures of general hygiene which relate to the community generally. Treatment was given to persons to prevent their becoming permanent invalids. The work done, that is, though preventive in intention, was curative in form.

In the early years of invalidity insurance expenditure on prevention was almost wholly on institutional

treatment. Expenditure of this kind is still very much the larger part of that directed to prevention. The individual, with his particular needs, and the liability of the insurance funds with regard to him, naturally loom largest in the eyes of the insurance authorities.

The other expenditure on preventive work is largely in subscriptions to philanthropic societies. Not all the work of these societies is by any means wholly preventive. Thus, the principal work of some of the societies is to provide district nurses, whose work appertains to the treatment of the sick more than to the prevention of disease.

The preventive work done by the insurance authorities by providing cheap loans for works likely to benefit the community must not be omitted. Loans have been given for drainage schemes, waterworks, and the like. Most important of all are the cheap loans for housing. But the provision of loans does not happen to be work in which it is so essential that the insurance authorities should be in constant touch with the public health authorities.

(*e*) Allowing that in the early days of compulsory insurance in Germany there were special reasons why closer connection was not made between insurance and public health, why was not this done in the recent revision of the law ?

German notions have become accustomed to see the two groups of authorities revolving in their own unconnected orbits. The insurance authorities have consolidated their preventive work. Most of it is still institutional. They do not embark much on general hygiene, except indirectly. The work they do in this direction is effected mainly through philanthropic societies. Moreover, public health work is very unequal in different parts of Germany, and at many places little is done. It would be difficult to erect a structure on piles of very different lengths.

These conditions sufficiently explain why in Germany the public health authorities and the insurance groups will still have little directly to do with each other, despite the reasons for systematic co-operation.

CHAPTER XX

General Conclusions

It will be advantageous to string together the several conclusions which have been stated in previous chapters. A better notion will thus be obtained of their full significance. Moreover, it is well to see what broad principles, if any, underlie the conclusions, and to test the latter accordingly.

In dealing with medical benefits, we have been treating of one phase of the general social problem. The conclusions at which we have arrived must be tried, would inevitably if put into practice be tried, not only by their efficacy in meeting the requirements of the particular problems immediately under review, but also by their accord with the fundamental needs of general social development. A wise physician does not treat a patient suffering from some disease with a view solely to the cure of the particular disease; he always has at the back of his mind the general constitutional needs of the patient. And the same applies to the social physician.

The conclusions which have been stated in previous chapters have been derived mainly from the lessons of experience in the administration of medical benefit. While there have been incidental references to the broader issues involved, endeavour has been made to keep close to the pressure of primary fact. If, then, conclusions so obtained are found to accord with the demands of fundamental social needs, this will afford strong additional testimony to their validity.

At the same time, since medical benefit is only one item, one phase rather, in the general social problem, it is probable that an intensive study of the question will throw

light on many another. And one does not need to probe very deeply into the conclusions which have been reached to find that this is so. Thus, as will be explained more fully later, certain aspects of the difficulties and of the tentative solutions with regard to the conditions and terms on which service should be rendered by doctors throw a flood of light on the problems which vex the industrial world at the present time, and are likely to vex it still more before a stable solution is reached.

The conclusions which have been stated in previous chapters are as follows :—

1. Medical service should be provided mainly in kind (p. 16).
2. There is advantage if societies, or federations of societies, deal directly with doctors, or associations of doctors, in matters of medical benefit (p. 19).
3. In sickness insurance free choice of doctor should be conceded (p. 43).
4. In insurance against disablement it is reasonable that the insurance authority should employ special doctors for examining claimants to pensions (p. 48).
5. If treatment by unqualified practitioners be allowed, it should be permitted only under strict guarantees and precautions (p. 50).
6. Medical practitioners will demand, and will probably obtain, higher rates of remuneration from the working classes than have been general in the past (p. 81).
7. Payments by sickness insurance societies or authorities for medical service should be in the form of capitation fees (p. 85).
8. It is reasonable that individual doctors should be remunerated according to services rendered (p. 88).
9. The combination of capitation payments by the sickness insurance society (or authority) and remuneration according to services rendered to the individual doctor is best secured when the society contracts with a corporation of doctors, making capitation payments to the corporation, and the corporation dividing the proceeds

among the several doctors according to their respective services (p. 90).

10. There are considerable advantages in making the insured person pay for part of the cost of medical service out of his private resources (p. 92).
11. Systematic provision should be made for educating the insured public as to medical treatment and in matters of health (p. 96).
12. The claim of the doctors that a distinction should be drawn between the terms on which medical service is rendered to persons with comparatively large earnings and persons with small earnings merits sympathetic consideration (p. 101).
13. It is essential that strict control should be exercised over medical practitioners in their treatment of insured persons, especially when there is free choice of doctor (p. 125).
14. Detailed control in expert matters should be exercised mainly through the organisation of the doctors themselves (p. 126).
15. The sickness society, or other pertinent insurance authority, should exercise strict general control through its own committee, assisted by a confidential medical adviser (p. 129).
16. Provision should be made for committees of conciliation and of arbitration (p. 130).
17. There is much advantage in securing some control of medical benefit through the patient, a control which is obtained if the patient has a direct and immediate pecuniary interest in preventing abuse (p. 131).
18. It is advisable that the provision of medical and surgical requirements, in major part or in whole, should be included in the benefits provided (p. 154).
19. There is much advantage in providing only part of the cost of medical and surgical requirements, especially if there are no other means, such as a deposit system, whereby members have individually to bear part of the cost of benefits (p. 156).

20. Societies should be allowed liberal discretion as to the manner in which medical and surgical requirements shall be provided (p. 157).
21. It is essential that there should be systematic control over the prescriptions ordered and the dispensing of the prescriptions (p. 159).
22. Systematic provision should be made for the general education of members respecting the use of medical and surgical requirements (p. 160).
23. The provision of institutional benefit is essential for adequate medical treatment (p. 192).
24. It is not practicable for workmen to provide adequate institutional benefit through their own societies without a liberal measure of assistance (p. 193).
25. It is not advisable that assistance should be given expressly for hospital treatment (p. 194).
26. Special precautions are necessary to restrict institutional benefit within reasonable limits (p. 197).
27. Medical practitioners should be remunerated in such a manner that they have not any pecuniary inducement to send cases unnecessarily to hospitals (p. 198).
28. The provision of an adequate system of home nursing is desirable. This has the incidental advantage of reducing any tendency to hospital abuse (p. 199).
29. The provision of maintenance in convalescent homes should be kept within narrow limits (p. 200).
30. Societies should be allowed to make their own conditions as to acceptance of hospital treatment by members with forfeit of other benefits if they refuse (p. 201).
31. There should be close and systematic co-operation between the insurance and the public health authorities (chap. XIX).

If the foregoing conclusions be analysed, it will be found that through them run a number of principles which may be applied, not only to questions of medical benefit, but equally to other social problems. I will set out each

principle separately and will briefly consider its significance.

(*a*) *Needs should be met by corporate provision.*

Detailed consideration of the kind of organisation through which insurance against sickness should be provided has been outside the province of the present volume. It has been taken for granted that some form of corporate provision is desirable. Nor, indeed, at this time of day, should this require emphasis. It is the only way in which persons of narrowly limited means can satisfactorily provide for the contingencies of life. Corporate provision is only the gregariousness of the human animal organised and made systematic. And the principle applies, not only to provision against sickness, but to other needs also.

(*b*) *Corporate responsibility requires to be tempered with a dash of individual liability.*

Accordingly it has been suggested that individuals should be required themselves to pay part—a small part—of the cost of medical service and requirements received by them.

Insurance is not simply a matter of money and organisation. It is a matter of mind also—of thought and conduct. Life is dynamic. Corporate responsibility, to be successful, implies a highly developed social habit, a habit which can be reached only after long experience. The habit probably does not at present generally exist in sufficient strength to dispense with all individual spur. Failure to recognise this may bring serious risks in its train. The cost of insurance may be increased, the very possibility of it perhaps endangered in some cases. Malingering may be encouraged and, a graver evil, valetudinarianism fostered.

In the absence of a sufficiently strong social habit for full corporate responsibility, the very introduction

of an individual bait may make for a deeper corporate spirit. To form organisations with only corporate responsibility when the necessary habits do not exist may simply mean that a very large proportion of the members will take practically no part and very little interest in administration. The experience of Germany confirms this. Introduce a direct individual incentive, and more individual interest, and truer democratic self-government may be gained.

The same principle crops up in the arrangements for medical service. Doctors as an organised body may accept corporate responsibility for the service; but payments to individual doctors should be according to work done.

(*c*) *Just as there is required corporate provision for needs, so also is there required corporate provision for functions.*

Corporate provision for functions follows in some directions on corporate provision for needs. Thus, if workmen provide through a friendly society for insurance against sickness, they incidentally provide in corporate fashion for the performance of certain functions necessary for managing the affairs of the society.

But it is as regards medical service that this question becomes of most significance. The conclusions at which we arrived were that the medical profession should corporately arrange with the insurance authorities for medical service, with a liberal dash of individual stimulus. In this manner, the way would be smoothed towards the solution of some of the thorny difficulties connected with medical service with which insurance bristles.

It may reasonably be asked, indeed, whether it would not be right to go further than has been suggested. If doctors should corporately undertake medical service why should their corporate responsibility not be extended to hospital, as well as to domiciliary, treatment. There are many things which can be said in favour of

such a development. The different kinds of treatment cannot be divided into watertight compartments. There should be organic relationship between them. And there is risk that this will not be secured satisfactorily and permanently unless all are under one jurisdiction.

Further, if doctors were corporately responsible for hospital treatment, with pecuniary interest, the difficulty of checking the abuse of hospitals by doctors, of checking the sending of patients there without sufficient reason, would be largely solved. Competition between voluntary, municipal, and private institutions might be avoided. An automatic check would be secured on the inevitable tendency of doctors to run up the cost of institutional treatment.

It seems highly probable that the day of the voluntary philanthropic hospital is passing. It has many hours more to run—fortunately so, for the community cannot do without it for a long time yet—and the system is capable of further extension still. But the general trend is against it.

The alternatives seem to be either public (state or municipal) hospitals, or hospitals run by the insurance societies and authorities, or hospitals under the direction of the organised medical profession. In favour of public hospitals is the fact that on the continent development has long proceeded apace in this direction. On the other hand, the impartial observer will not be very enthusiastic of the results. And, as we have seen from the arguments put forward in the third chapter, there are objections to a wide extension of a public medical service.

There is something to be said in favour of the provision of institutional treatment directly by the insurance societies and authorities. Against it there is the objection that the organic relationship between different forms of medical service is lost.

There are no signs in any country that the organised

medical profession is likely in the near future to take, or to be allowed to take, institutional treatment in general under its wing. Even in countries where there has hitherto not been much tendency towards municipal provision of institutional treatment, it is not unlikely that the first steps in the immediate future will be in this direction. And insurance societies and authorities may also be induced to extend provision of this kind made by them. The pressing needs of the moment must be met in the way that lies handiest and most in accord with the notions prevailing at the moment. But the permanent development may lie in quite another direction. The eastward river may make long bends to north or south, but its ultimate course is towards the rising sun.

It does not follow that, if the administration of institutional treatment were undertaken corporately by the doctors, that they would provide the plant, the capital expenditure, required—buildings and equipment. These might be provided by public authorities or by insurance societies or authorities. The essential matter would be that treatment should be under the primary control of the organised doctors.

This consideration of institutional administration is a digression, but a digression which raises many points of interest. It suggests a development which, while certainly not immediate in existing conditions—the medical profession itself is not ripe for it—may yet come to pass. If society is to be organised increasingly and with stability, specialisation of function by groups will grow. And just as the human organism has specialised its legs for progression and only uses hands or other part of the body for the purpose in emergencies, so also the body social may specialise a group within it for a particular function, and only use some other organisation in exceptional circumstances.

It is in the case of the doctors that this question of the

provision through corporate organisation for the performance of functions is most acute. But it arises also in the case of pharmacists, more especially so in those countries, such as Germany and Denmark, where the work of the pharmacist is clearly differentiated, though there the position is much affected by the stringent regulations to which the pharmacist is subjected. In so far as the work of the pharmacist is recognised as a distinct profession, and the tendency is strongly in that direction, what has been said with regard to the doctor applies essentially to him also.

It will be manifest that the foregoing observations on the organisation of medical service touch some of the most difficult problems of modern industrial life. Recent developments have brought the medical profession into the full stream of economic development. Doctors have at least learned the significance of the strike and the boycott—and incidentally have gained a deeper insight into, and sympathy with, the difficulties which confront the working man, and the devices to which he has to resort, than they ever had before.

But they are surpassing the working man. They have already in some places in Germany gone beyond corporate bargaining and undertaken corporate liability for service and control. They may thus yet show the working man the path to new fields of development, and heal more than they suspect. They are in a very favourable position to do so, once some of the shackles of professional etiquette and reserve are broken. Educated above the standard of the workman, gifted in most cases by the very nature of their work with a rich fund of public spirit, freer from the trammels of capitalist restraint, they can respond more quickly to the needs of modern conditions than the average workman and can thus fashion out new moulds of organisation while he is still painfully groping his way in the darkness.

Development in this direction of specialised group function with corporate responsibility of course has its dangers.

Most things that count have dangers. But it probably offers the one way of permanent peace and efficiency. The pressure of the different groups on each other affords a safeguard. And a firm, though indulgent, common control would be elaborated. Further, modern life is distinguished crucially from earlier times in that the well-developed man has many interests; he will be a man of many groups and automatically will tend to refrain from pushing any one interest to extremes.

(*d*) *The corporate groups, whether provided to meet needs or functions, must be democratically organised and administered.*

So far as the present volume is concerned, this question becomes most prominent in connection with the control of doctors; the organisation and administration of insurance groups has not been considered. As regards the doctors, democratic administration becomes manifest in—

(i) Freedom from unnecessary external control.

The workman has to realise that, if he imposes needless control over the work of the doctor, whether individually or through his society, or if he imposes in either of these ways control which could be equally well exercised by the doctors themselves, he is violating the demands of democracy no less essentially than does a tyrant who exacts forced labour at the point of the bayonet. In the scheme of medical administration suggested in the conclusions, it is proposed that the doctors should organise their own system of control, subject to the general supervision of those to whom they render service. This conclusion was deduced from practical needs; it offers the best form of control. It is now seen that it also accords with the broad claims of democratic development.

Likewise as regards remuneration. The insurance society should settle with the doctors' organisation

what should be the aggregate payment; the mode in which the payment should be distributed among the doctors should be left mainly to be decided by themselves.

(ii) Democratic organisation and administration of the corporate group of doctors.

This is a matter primarily of domestic medical politics, and therefore has not been considered at length. But a system under which there is free choice of doctor clearly implies that ordinarily every doctor should be free to join the medical organisation, and that each should have an equal voice in management and control.

(*e*) *A generous measure of freedom must be allowed.*

The question of freedom arises firstly in regard to the insurance of the workman—freedom of organisation. This is outside our present purview. It also arises acutely in a number of instances in connection with medical benefit. The proposals which have been made tend strongly in the direction of making medical organisation firmer. The position would recall that of the old guilds —but not necessarily the autocratic power and the narrowness and ultimate downfall of the latter. These failings have to be prevented. As already explained, there would be a number of strong means of control, such as the pressure of other groups, more especially the insurance groups; the control of a common authority; the fact that the modern man has many interests and is not concentrated on one. Further express recognition of freedom would be needed. In the long run, this is essential for the survival of the medical organisation itself; it would burst under its own pressure without this safety valve. It is also demanded by the spirit of modern tendencies.

Apart from the admission of this principle in what has already been said respecting democratic control, there are some conclusions which expressly meet

the demand for freedom. Foremost comes the free choice of doctor by the insured. Correspondingly, on the practitioner's side, comes freedom to practise among the insured, provided that he fulfils the minimum essential requirements.

The case of the qualified practitioner who, for reasons good or bad, does not wish to enter into the fold of the organised doctors requires consideration. Though from the point of view of the doctors, as of industrial workers, there is something to be said for making their organisation, by coercive means if need be, co-extensive with their profession, it would be difficult to uphold this from the point of view of ultimate social well-being. Coercion is a sign of weakness—and may be justified by weakness. The community as a whole cannot easily afford any group within its borders to grow strong unless with strength goes enlightenment. Firmness of organisation and tolerance should go together. It would be an unwarranted restriction of the freedom of the insured to confine them in their choice wholly to the organised doctors. Further, for broad social reasons, it is not well that the way of the unorthodox should be made too hard. Once doctors in general are firmly organised and, thus organised, are recognised as the authority with whom, so far as treatment of sickness is concerned, terms are primarily to be arranged, they can well afford to be generous and not attempt to exclude qualified practitioners without the fold from the treatment of insured patients.

(*f*) *Emphasis is laid on educational work in insurance.*

This falls into line with the whole trend of modern thought. That insurance scheme which proposes simply to treat sickness is not likely to achieve very great benefit. Whatever success it may attain, it may, unless wise precautions are taken, sow almost as many, if not more, evils than it removes. It is not enough to treat ailing plants or even enough to remove

the weeds ; the soil must be enriched and strengthened. Measures are too often applied to the social organism as though it were static, whereas it is dynamic : too often as though it were mechanical, whereas it is biological ; it responds to new conditions, often in very unexpected ways, and adapts itself to new circumstances, often in modes most disconcerting to the undiscerning.

It is an essential corollary of the democratic organisation of insurance that provision for the education of the insured should be well developed. They must attain that plasticity of habit, that readiness to acquire new modes of thought and conduct, which will alone enable them to respond to the needs of growing experience and of changing conditions. And they must learn from experience what the new habits must be, realising that steady change is the one condition of strong survival, and that the one way of ascertaining what is the next step forward to be rightly taken is by scanning experience with steady persistence.

This side of the problem is so important that a volume might well be written on it alone. But it must be sufficient to indicate just a few points. In matters of health, there has been a growing tendency during recent years to emphasise personal hygiene —the acquisition of personal habits conducive to health. This can only be done effectively through education, at least under democratic organisation. As previously stated, insured persons must live near enough to the hard core of fact, must receive the lessons of experience in sufficiently simple and direct form, that they cannot but realise the needs of prevailing conditions and take action accordingly. The cloistered virtue is not for democracy.

Then, again, there is the influence of mind on physical ill, to which brief reference has been made in previous chapters. On the negative side lies the grave

danger of valetudinarianism, which must be systematically combated. On the other side lies the possibility, with enlightened progaganda, of securing healthier thought and quicker response to ascertained needs.

There is on the average more of mentality in the life of to-day than formerly. Man lives less mechanically. There is more deliberation, more definite mental effort in mapping out courses and ways and means. Mere instinctive reactions count for less. Hence largely the need for, and the emphasis on, education—not set education in the school sense (there is already in some ways too much of this), but the education which comes to a ready mind in touch with actual fact. And this larger mentality has its dangers. We are dealing with a finer, more plastic instrument. It can be turned to more diverse and more excellent purposes. But it can also be degraded to baser levels, and that not only deliberately, but also sub-consciously. A man rooted in instinctive courses may scarcely be touched by a suggestion of ill to which a man of more malleable mind may easily fall victim. And so we find persons groaning under the weight of minor ailments which a healthier outlook would throw off with a shrug or almost wholly disregard, leaving them to the automatic rebound of a recuperative physique, with excellent results. And so again are we driven back to the problem of valetudinarianism, which indeed is one of the greatest of the incidental problems, not only of insurance, but of all concerted measures for health, a problem only to be met by systematic democratic education.

The conclusions which have been put forward would not solve all difficulties, fortunately. There would remain several matters which would give rise to friction, foremost among them that of remuneration. I have made no endeavour to state a sum at which remuneration should be fixed. Obviously, the rate of remuneration must vary

with time and place. It is essentially a problem which can only be solved by a succession of agreements. It is itself conditioned by changing circumstances; that is manifest from what has already been written in previous chapters on the subject.

There must be frank recognition that the matter is one for gradual adjustment, and proper machinery for conciliation and arbitration needs to be provided. That is the best way of peace. Even then there will doubtless be an occasional outbreak. Those who ask always for a smooth journey demand from existence more than it can give, more probably than it is well it should give. Life would be duller, and on the whole lived at a much lower level, without the occasional storm.

The provision of medical benefit through insurance presents formidable problems. Some of these problems, as we have seen, do not arise wholly from insurance. They are inherent in existing social conditions. Insurance does but focus and intensify them. At the same time, by the very fact of doing so, it affords better opportunities for systematic efforts at solution. The thing of essential importance is that the broad principles of action should be well and truly planned, that the general direction should be judiciously mapped out. That done, however many the little mistakes and mishaps that may happen by the way, they can be effectively remedied by wise ingenuity.

APPENDIX I

MEDICAL PRACTITIONERS IN GERMANY: ORGANISATION

In Germany, civil medical practitioners are officially grouped into local associations. Certain legal functions are fulfilled by these associations. They elect medical councils, by which some medical discipline is exercised.

I do not propose to deal with this official organisation, and will confine myself to the more interesting extra-official associations. But it is worthy of note that the German doctors first tried to regulate their conditions of service with sickness insurance societies, and to protect their interests, through the official organisations. Medical councils sought to lay down the terms on which service should be rendered, and threatened penalties if compliance was not given to their directions. But the governments held that intervention of this kind was outside the province of the councils and forbade it. In Austria and in France likewise, the official medical councils tried to forward the interests of the doctors in similar manner, and were similarly warned off by the governments.

Medical practitioners are now very strongly organised in Germany outside the official fold. This is mainly a direct consequence of the pressure brought on them by the insurance laws.

A society (the *Aerztevereinsbund*), which roughly corresponds with the British Medical Association in this country, had been in existence since 1873. In 1900 another society was started—*der Verband der Aerzte Deutschlands zur Wahrung ihrer wirtschaflichen Interessen*, commonly known as the *Leipziger Verband*. As its name implies, this society was organised to protect the economic interests of doctors, especially against sickness societies. In 1903, the society joined hands with the *Aerztevereinsbund*, and now forms the branch of the

organisation of the doctors which looks after their economic interests.

The *Leipziger Verband* is frankly a trade union of medical practitioners. It exists to improve their conditions, and is an aggressive, fighting machine. On May 1, 1911, it had nearly 23,800 members, which is stated to have been over 95 per cent. of the medical practitioners in Germany who need to be taken into account for the purposes of such an organisation.

At first the society hoped to secure its ends by legislation. But in 1903, after failure to secure its aims in the insurance law passed in that year, the society, by resolution passed at the annual meeting of the year, definitely took up the methods of "self-help"—that is, independent action on trade union lines, enforced, in the ultimate, by strike or boycott. The action of the doctor, not less than that of the ordinary industrial worker, in turning away from legislative hopes and trusting to the independent strength of his organisation is significant. Moreover, in the conditions brought about by the new law, the doctor is threatening the general strike.

And certainly, on the whole, the doctors' campaign has been very successful. They have not gained all they wanted, but they have won a great deal—in numerous places, free choice of doctor and largely increased remuneration. The campaign has in many cases been enforced by strike or boycott. Two of the most important—and bitter—conflicts have been those at Leipsic and Cologne, of which particulars are given in appendices III. and IV.

The action of the doctors, when driven to extremes, takes the form of refusing to treat members of the insurance societies on the terms offered. Hitherto, conflicts have been confined to the locality immediately concerned. The doctors have not yet developed the sympathetic strike, though now, as previously stated, they threaten a general strike. But the doctors' society tries, of course, to prevent outside doctors from coming into the affected area from other districts to spoil the game.

Provision is made for assisting doctors who suffer from the strike, if they are in need. In the report of the *Leipziger Verband* for 1910–11 it is written—"Not only the conflicts in Cologne and Bocholt, but also the dark future before us, make it essential that the association should accumulate a heavy war chest. Our organisation must be equal to every emergency. But this is only possible when large resources are available.

"Regular contributions, in some cases of considerable amounts, are made by a large number of associations of doctors and of organisations of sickness society doctors, especially those at Munich, Leipsic, Mannheim, Frankfort-Main, Wiesbaden, Elberfeld, Remscheid, Kiel, Königsberg-Prussia, Minden, Stettin, Charlottenburg, Zerbst, &c. But the great majority of the associations take little or practically no part in financially strengthening our war-chest."

In the same report the following summary is given of conflicts between societies and the organised doctors.—

Total number of conflicts	1,022
Decided in favour of the doctors	921
In favour of sickness societies (for the time being)	11
Still pending on May 1, 1911	90

It is stated that all the conflicts of the year 1910–11 were decided in favour of the doctors. The association may be overstating its victories, but it seems clear that the doctors hold a strong position.

It has been alleged that strike-breaking doctors employed by sickness societies have been of inferior competence, and that they send to hospitals a large number of cases which would, in ordinary circumstances, be treated at home. A demand has therefore now arisen that at least the doctors employed at hospitals as assistants should take sympathetic action with the organised doctors, if it is found that hospitals are being improperly used by strike-breaking doctors.

While relying mainly on independent action, the doctors' society has not failed to press hard the claims of its members in any legislative proposals touching them. The society tried strenuously to get provisions inserted in the new law which would secure them much of what they wanted, but not with great success.

The sickness societies have not looked on complacently while the doctors have been arming themselves. The committees of societies have been hampered to some extent by the desire among large numbers of their members for free choice of doctor. And many societies, among them the largest in Germany, that at Leipsic, find it better to come to terms with the organised doctors and to work amicably with them.

But this is not the attitude of the majority of the leaders of the sickness societies. It has been previously mentioned that, at the general meeting of the district sickness societies held at Dresden in 1911, the predominant feeling was strongly against free choice of doctor. The federation of establishment societies is equally against free choice.

One of the means of combatting the *Leipziger Verband* has been to encourage an opposition organisation of doctors—the *Reichsverband deutscher Aerzte.* This society is against forcing free choice on the insurance societies. It has been strongly supported by the federation of establishment insurance societies. But the *Reichsverband* is not strong, and is not likely to be a very potent force in the German struggle between doctors and sickness societies.

APPENDIX II

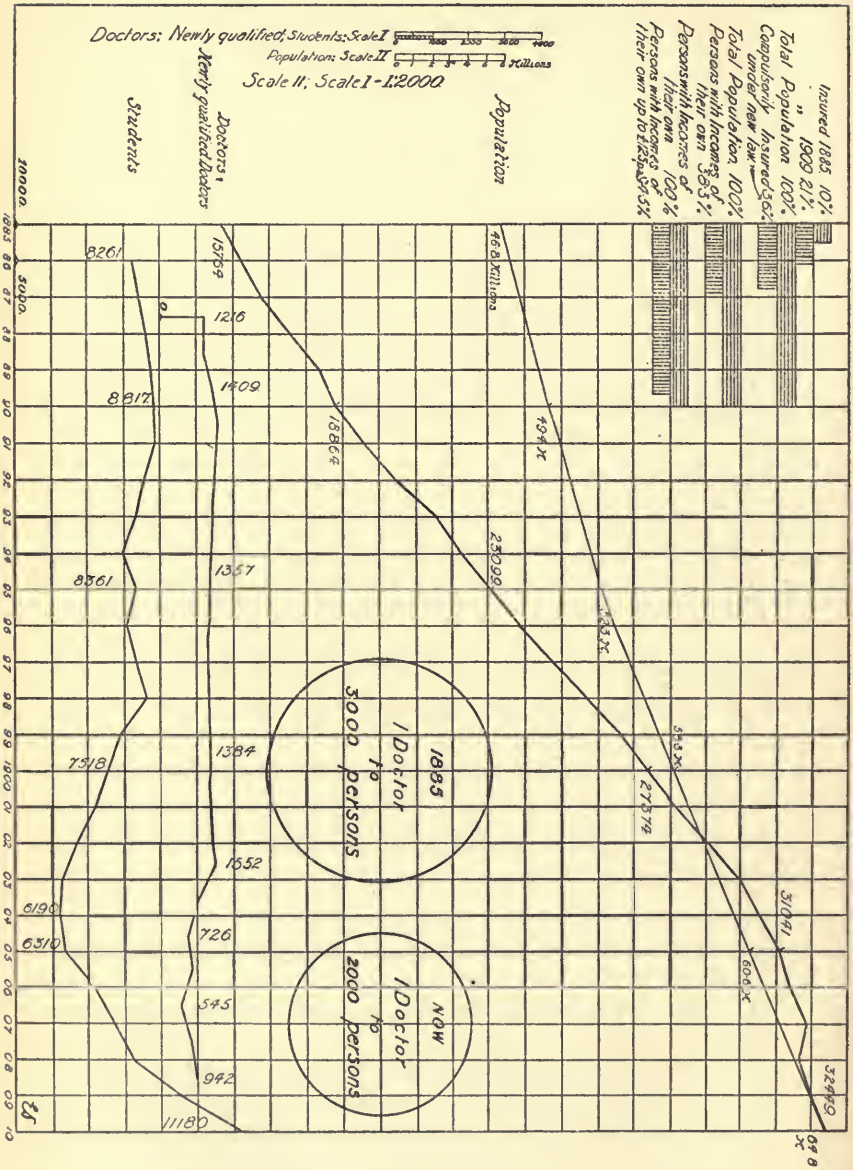
MEDICAL PRACTITIONERS IN GERMANY: PROPORTION TO POPULATION, &c.

THE chart below appears in a booklet by Dr. E. Sardemann, of Marburg, entitled "*Wer soll und wer darf Arzt werden?*" ("Who shall and who may become a doctor?"). A similar chart appeared in the *Aertzliche Mitteilungen*, the organ of the *Leipziger Verband*, the doctors' organisation, for January 13, 1911. The booklet is published by the *Verband*, and sets out briefly some particulars respecting the training, work, and prospects of doctors, and is distributed to students leaving the high schools, in order to prevent a thoughtless overcrowding of the medical profession. I am indebted to Dr. Sardemann and to the *Verband* for permission to reproduce the chart. The curves indicate, for the years since 1885—(1) the total population of Germany; (2) the total number of qualified doctors; (3) the total number of new doctors qualified each year; (4) the total number of medical students each year. The circles indicate the proportion of doctors to population in 1885 and at the present time. The columns in the left-hand corner of the chart give information respecting the proportion of the population which is insured against sickness.

The chart, though a little complicated, brings out in graphic form a number of important facts. Among these may be mentioned—

1. The large increase in the number of doctors proportionately to the population.

   This is manifest from the two first curves and from the circles. The rise in population and in number of doctors has been steady. But it has been much larger in the latter than in the former. Comparing 1885 with 1910, the population has risen less than 40 per cent; the number of doctors has risen over 100 per cent.


Doctors: Newly qualified; Students: Scale I
Population: Scale II
Scale II; Scale I - 1:2000
Insured 1885 10%
" 1909 21%
Total Population 100%
Compulsorily Insured 35%
under new law
Total Population 100%
Persons with Incomes of £160 & under 95%
Persons with Incomes of £160 & their own up to £250 & 95%
Students
Newly qualified Doctors
Doctors
Population
10000.
5000.
8261
8817
8361
7318
6190
6310
1576
1216
1409
1384
1552
726
545
942
11180
18864
46.8 Millions
494 x
235099
733 x
515 x
273 79
1885
1 Doctor to 3000 persons
NOW
1 Doctor to 2000 persons
3104
806 x
3280
94 8

There was a break in the rate of increase of doctors in the latter part of the last decade. This was due partly to the fact that the medical curriculum was extended by one year in 1903, students being required henceforth to spend a year in practical work before they can become fully qualified. Certain concessions were made to persons nearing the end of their studentship, and the new regulation did not become fully effective for some time. This additional year of training also affects the curves which indicate the number of new doctors qualified and the number of students.

2. The number of new doctors qualified each year and the number of students in each year remained fairly constant at first, but in the later years there was a fall, which has been succeeded by a rise.

There has been a rapid rise in the number of students from 1905 to 1910. This is a disconcerting fact to the doctors and threatens a reinforced burst of competition.

The fact that the curve of the number of new doctors is fairly even for a large part of its course goes to indicate—

(*a*) That the rise in the proportion of doctors to population is due, not to an unusual influx of new doctors, but to the fact that the number of new doctors has for years been more than was necessary to replace the wastage.

(*b*) That the causes which have produced the increasing proportion of doctors to population were in operation before the coming of imperial insurance. Of course, it is possible that they would have ceased to act in the subsequent years, or not acted so vigorously, were it not for the existence of the insurance schemes.

3. Instructive also are the columns in the left-hand corner of the chart. They show—

(*a*) That an increasing proportion of the population has become insured;

(*b*) that the new law will bring another very large contingent under compulsory insurance[1];

(*c*) that the limit of £125 per annum, which is the new income limit for compulsory sickness insurance, comprises some 94 per cent. of persons with incomes of their own. Among this class, there will not be a large proportion left for private medical practice.

[1] 36 per cent. seems a high estimate.

The chief object of the chart is to show the rise in the proportion of doctors to population—and therefore the growing gravity of the situation for doctors and medical students—and the increasing proportion of persons who are insured. In interpreting the facts indicated, there are a number of important considerations to be taken into account.

1. The second curve shows the total number of doctors. It includes doctors in the army and in hospitals, sanatoria, and similar institutions. These, it may be urged, should be taken into account for they participate in treatment of sick persons just as does the ordinary practitioner. It also includes medical officers of health, doctors employed in research, and in other ways which keep them out of treatment of the sick. Doctors of these classes are an increasing number. At the same time, they probably do not account for a very large proportion in the total increase in the number of doctors.
2. The number of doctors in 1885 in proportion to the population may have been too low. Roughly, it was 1 to 3,000. The writer of the article himself appears to imply that 1 doctor to about 2,500 population would not be excessive. But in 1910, the proportion had risen to 1 to 2,000. Many persons would hesitate to say that even this was too high.
3. Connected with this question is the undoubted fact that there is more demand for the services of doctors to-day than formerly. Persons require their services more frequently. They are requisitioned more readily for slight ailments which our ancestors would have allowed to run their course, to good or ill, without medical aid — at least until, if to ill, conditions became very serious. Doctors themselves strongly aver that insured persons seek the services of the doctor at the slightest excuse. No doubt insurance does intensify the charge. But it exists even apart from insurance.
4. Account must be taken of the distribution of doctors. They are not evenly scattered over the land so that, where 2,000 persons are gathered together, there is a doctor in the midst of them. Doctors naturally congregate most where there is wealth. Generally, though there are exceptions, in proportion to the poverty of a district so is the fewness of doctors. It seems safe to say therefore that, if 1 to 2,000 is the average ratio of doctors to population, the ratio is higher in wealthy and well-to-do districts, and considerably lower in

working-class districts and much lower in the poorer working-class districts. So that it is not likely that in working-class districts the proportion of doctors to population is above the 1 to 2,500 standard.

Further, in addition to differences of distribution according to the wealth (or poverty) of the clientèle, there are differences according to locality (though the latter differences frequently merge into the former)—differences of town and country; differences due to the amenities of life in the different localities; &c.

The foregoing considerations may modify the conclusions to be drawn from the indications given in the chart. But the chart, when all necessary deductions are made, brings out in telling form some facts which are of cardinal importance, not only to the doctors themselves, but also to the community in general.

APPENDIX III

CONFLICT BETWEEN THE LEIPSIC DISTRICT SICKNESS SOCIETY AND THE ORGANISED MEDICAL PRACTITIONERS[1]

THE Leipsic Society had long given choice to its members among a large number of doctors. In 1904, the society, which then comprised some 140,000 members, had agreements with 233 doctors for treatment. 4s. 6d. per member per year was paid for medical service. Medical treatment was given to dependants of members as part of benefit.

The doctors demanded higher rates. They asserted that the capitation payment of 4s. 6d. only sufficed to give about 50 per cent. of the rates of 1s. for a visit, 9d. for a consultation. They asked for payments of 4s. per member without dependants, 12s. per member with dependants.

The society said that these demands were impossible, and that they would ruin the society. They offered a capitation payment of 5s. 6d. per member. The doctors would not accept.

In addition the doctors demanded, and on this they laid much stress, that there should be organised free choice of doctor, and that new terms of medical service should be arranged between the society and the medical association, and that the agreements with individual doctors should not be terminable at the will of the society.

Endeavours were made by the supervisory authority to arrange a settlement of the dispute, but without success. The doctors gave notice to terminate their services on April 1, 1904. They were loyally supported by practically all the other

[1] Dr. Bernhard Puppe: *Die Bestrebungen der deutschen Aerzte zur gemeinsamer Wahrung ihrer wirtschaftlichen Interessen*, 1911, pp. 115–124.

doctors in Leipsic and the neighbourhood. Moreover, the university medical professors and teachers refused to treat society patients in the university clinics.

The society adopted special measures to meet the emergency.—

1. They imported doctors to whom they guaranteed an income of at least £300 a year. The doctors were to be allowed to engage in private practice as well.
2. They established three consultation centres, under the charge of whole-time medical officers, with incomes of £400 a year, with assistants.
3. They undertook to pay, at the minimum rates of the State medical tariff, for such necessary medical treatment to members or their dependants as could not be given by the society doctors.

The doctors also pursued an active campaign. They decided that they would not treat members of the society on any terms. They took steps to dissuade doctors from entering the service of the society. Of the seventy-five who had undertaken to enter the services of the society, only sixty-two came.

The society found itself in severe straits. Medical benefit to dependants of members was dropped so as to lighten the demands on the society for medical service. But this did not ease matters much for the organised doctors could still refuse to treat the dependants.

The supervisory authority was petitioned to intervene and to compel the society to provide adequate medical service. The authority decided that at least 112 doctors were necessary for the proper treatment of members, and demanded that the society should increase the number of its doctors. The society was unable to fulfil the requirements, and the authority consequently made agreement with the organised doctors, in the name of the society, for the treatment of members and dependants. The agreement was made until the end of 1910 and provided for—

1. Free choice of doctor.
2. Payment at the rate of 5s. per member without dependants, and, in the case of members with dependants, 3s. per person entitled to benefit, including dependants. Special payments were to be made for midwifery cases and for mileage. If the total expenditure of the society on money benefit and medical and surgical requirements exceeded a

certain sum, the excess was to be deducted from the payments to be made for medical service.

3. As regards the doctors with whom the society had entered into agreements guaranteeing them a minimum salary, payment to these doctors was to come out of the amounts paid in capitation fees. But the society was to take the earliest legal opportunity of terminating the agreements.
4. Provision was also made for the establishment of committees for controlling the doctors, and for settling disputes.

The society tried to get the decision of the supervisory authority reversed, but did not succeed. Its weapons, however, were not yet exhausted. Medical treatment to dependants was again removed from the list of benefits. The total amount to be paid in capitation fees was thus much reduced. It amounted to about £35,000 a year in all. But out of this had to be deducted the salaries of the imported doctors, and these amounted altogether to about £25,000 a year. There was therefore not very much left for the organised doctors.

And for the medical treatment of dependants of members, a special association was formed, in which, for the payment of a small sum, treatment was given by the salaried doctors of the society.

Attempts were also made to boycott the organised doctors and thus to ruin them. The organised doctors in turn, controlling the official medical organisations, used them to punish the salaried doctors of the society.

The measures taken by the society were only partially successful. The special association did not attract a very large number of members. The society decided again to give medical benefit to dependants. And the consultation centres also were soon closed. They were costly, and the numbers attending them fell.

Ultimately in May 1905, the society and the organised doctors came to terms—

1. There was to be free choice of doctor.
2. Payment was to be as fixed by the supervisory authority except that—
   (*a*) the amount to be paid per person, where there were dependants entitled to medical treatment, was fixed at a lower figure ;

(*b*) the society undertook to pay one-sixth of the sum payable to the salaried doctors over and above the capitation payments.

This agreement appears to have worked satisfactorily, and the Leipsic Society has now become one of the principal supporters among sickness societies of the organised free choice of doctor. In 1910, the agreement was renewed for six years with some slight alterations, including better terms of remuneration. A translation of the new agreement made in 1910 is given in appendix V.

APPENDIX IV

THE CONFLICT BETWEEN SICKNESS SOCIETIES AND MEDICAL PRACTITIONERS AT COLOGNE

Sickness societies at Cologne at first employed district medical officers, giving their members, therefore, no choice of doctor. But already in the 'nineties some of the societies had conceded free choice among a limited number of doctors appointed by them. As elsewhere in Germany, there had been a rise in the rates of remuneration paid to doctors.

But the organised doctors were not satisfied. They demanded organised free choice of doctor, higher remuneration, and better conditions of service. To secure these objects the doctors employed by the sickness societies gave notice to terminate their agreements at the end of 1903. This action was taken partly because of the failure of the doctors in Germany to secure their demands in the insurance law passed in that year, and their resolution in consequence to turn to a course of independent action for securing their aims.

The sickness societies placed their case in the hands of the Federation of Sickness Societies in Cologne, to which were affiliated not only district societies, but also establishment and guild societies. The Federation proceeded to secure the services of doctors from outside Cologne. At the same time negotiations with the Cologne doctors were continued, in the hope of a peaceful settlement.

But the measures taken were in vain, especially as some of the doctors on whom the societies had relied refused to continue their services, in violation of their contracts. Complaint was made to the supervisory authority that the sickness societies were not providing a sufficient number of doctors for proper treatment. The authority required the societies to provide more doctors within a very short time. They failed to do so, and therefore agreements were made with the organised doc-

tors over the heads of the sickness societies by the supervisory authority for the treatment of insured persons. Appeals were made against the decision of the supervisory authority, but fruitlessly.

The agreements provided for the free choice of doctor, and for payment of remuneration at the rate of five shillings per member per annum. They were made for five years, to remain in force until the end of January 1909.

Before the lapse of this period fresh efforts were made to bring doctors and sickness societies into harmony. Municipal and State authorities tried to mediate, but without success. The doctors were confident that they could keep the societies under their yoke. The societies were determined to make a bold bid for freedom rather than concede what they considered the exorbitant demands of the doctors.

The feeling between societies and doctors was embittered by the fact that the former had taken action against the doctors who had seceded in 1904 and broken their contracts.

The societies, finding that an agreement was not likely to be reached between them and the doctors, began recruiting in different parts of Germany, through the Federation, for doctors willing to serve them on the terms offered. When the critical time came they were thus able to satisfy the supervisory authority that they had a sufficient number of doctors for providing adequate treatment to the members, and the compulsory medical arrangements with the organised doctors were not renewed.

The societies have now in their service from seventy to eighty doctors, including specialists. All, except about fifteen, have been imported by the societies—"blacklegs," the trade unionist doctors would call them. Some of them are doctors who had previously been employed by the Leipsic society in its struggle with the organised doctors. Over three hundred organised doctors, adherents to the *Leipziger Verband*, stand outside in opposition to the sickness societies. Gleaned from various parts of Germany to meet an emergency, it is scarcely to be expected that the average standard of the imported doctors is high. And if the statements of the opposing side be true, some of them bear tarnished records. But with their aid the societies, for the time being, are victorious. But the end is not yet, and the fight is still being waged.

The societies assert that under the compulsory arrangements

the cost of medical service was very high, that the societies were not able to exercise practically any control over the doctors, and that the latter ordered drugs, &c., and gave certificates of inability to work much too freely, with the result that the expenses of the societies were very largely increased.

In the report of the Federation of Sickness Societies for 1906 it was estimated that the expenditure of the fifteen district societies of Cologne and the neighbourhood on medical and money benefit had increased 49 per cent. from 1903 to 1906 (after allowing 4 per cent. increase as due to extension of benefits under the law of 1903), whereas during that period the membership had only increased a little over 21 per cent.

Another contention urged by the societies was that, even with the wide freedom of choice which prevailed, experience showed that a few doctors secured most of the patients, and that those reaped the richest harvests who were the most ready to give certificates and prescriptions to suit the desires of their clients.

The organised doctors retort that, under the conditions now prevailing, insured persons do not receive proper attention, alleging that some of the doctors employed are not competent, and that, owing to this want of skill of the doctors, and their unwillingness to give the necessary attention to troublesome cases, patients are sent to hospitals who could well be treated at home under a proper system. The journal of the organised doctors occasionally contains sarcastic records of alleged improper treatment of cases at Cologne.

With regard to the doctors' charge that patients are unnecessarily sent to hospitals under existing conditions of medical treatment, the societies deny that this is so. In the largest of the district societies, which includes men and women employed in several different employments, most of them not highly paid, the average expenditure per member on institutional benefit was less in 1910 than in 1908, but it was larger than in most previous years, and in the next largest district society, that for handworkers, the cost was higher in 1910 than in any previous year. Statistics are given at the close of this appendix which show the average expenditure per member on benefits in the two societies for a number of years. It will be remembered that the period of compulsory medical arrangements was from April 1904 to January 1909.

The following table shows the amounts which were paid in institutional benefit in the years 1906–7–8–9 by all the (*a*)

district societies, (*b*) establishment societies, (*c*) guild societies in the Cologne district for every £100 spent in money benefits, including sickness, confinement and death benefits—

		1906	1907	1908	1909
		£	£	£	£
(*a*)	... ...	27	27	34	36
(*b*)	... ...	21	25	25	26
(*c*)	... ...	94	92	108	111

There has been a progressive rise, but the jump from 1908 to 1909 does not seem to be so great as to be very significant.

Where lies the truth in the conflict of contentions between doctors and societies ?

1. Judging from general indications, members of sickness societies must suffer to some extent from the want of highly efficient medical service. With doctors recruited as at Cologne it would indeed be surprising if it were otherwise.
2. The societies have had to pay much more for medical service since the doctors took concerted action. This will be manifest from the statistics given at the close of this appendix. These show that, before the breach with the doctors in 1904, one of the societies to which the statistics relate had been paying less than 3s. per member per annum for medical service ; the other (with a higher class membership), under 6s. During the period of compulsory medical arrangements, the amounts rose to over 5s. and 8s. respectively, and, significant fact, have remained at these levels since the compulsory arrangements came to an end and the societies have regained the upper hand.
3. The societies are compelled to grant a considerable measure of choice of doctor. True that they are employing only about 80 doctors, and that the other 300 or more doctors of Cologne who stand firm by their association are excluded from the perquisites of insurance. But members have free choice among the doctors who are employed, and the societies find it expedient to advertise prominently that they give free choice.

Clearly, whereas outwardly present victory lies with the societies, the doctors have made large gains (though for the present, in Cologne itself, the fruits go to persons regarded by the organised doctors as "blacklegs")—largely increased remuneration ; limited free choice of doctors ; no inconsider-

able steps these towards the goal at which the organised doctors are aiming.

4. But there is another fact which the statistics make clear. Under the regime of the doctor triumphant the burden on the insurance funds was becoming intolerable. Not only was the cost of medical benefit largely increased, but also the cost of other benefits. Thus, in the largest of the Cologne societies, the average total benefit per member per annum during the last three years (1901–3), before the compulsory medical arrangements were made was but 26s. 2d.; during the last three years of the compulsory arrangements (1906–8), it averaged 35s. 1d.

   This enormous increase jeopardised the existence of the society. It was compelled to increase its contributions to the maximum allowed without the express consent of the employers. And yet it could not pay its way. Its reserves gradually diminished. The society would have had to take further steps if some change had not been made. A change was made. The compulsory arrangements with the doctors came to an end. New medical arrangements were made, and in 1909 the total average expenditure per member had fallen to 33s. 11d., and in 1910 to 33s. 3d. And, profiting by the reduction, the society has been able to start rebuilding its reserves, while at the same time adding to its scale of benefits. Part of the fall in expenditure may have been due to causes extraneous to the medical arrangements, but the latter were the main factor in the change.

It is manifest that there are two strong sides to the question. Doctors will demand and will get increased pay. They and the sickness societies are in part the victims of circumstances. Formerly, doctors treated members of the lower working classes at less than cost price; now they have to demand cost price, and a little more. On the other hand, in many cases, the remuneration of a labourer is unfortunately barely adequate to pay even cost price for medical service.

Doctors, and patients too, will demand free choice of doctor. Societies will resist, but they will resist ultimately in vain. Free choice, within reasonable limits, will have to be conceded.

Societies know full well that strict control over medical service, including control over the giving of certificates of inability to work, over malingering, and, still more insidious

enemy, valetudinarianism, is vital to their prosperity, vital even to their existence. So vital is it that it must be secured in some way or other. But doctors do not adequately realise this. They are apt too readily to give certificates of inability to work. Reared in the easy standards of their own social class, they are not strict enough with their patients to suit the standard of the working man. There will not be complete amity between doctors and sickness societies until the former realise this, until in some way or other they are prepared themselves to exercise control as strict as that of the societies.

The struggle has without doubt been grievous for Cologne itself. But its influence in Germany as a whole may well be salutary. It is an object lesson so striking that it cannot be overlooked. Societies will learn that they cannot hope to present an unbroken front to the demands of the doctors. Doctors will learn that with them lies the imperative responsibility of seeing that the funds of the sickness societies are not frittered away in relieving cases, which, judged by the stern standards of working-class needs, should not require assistance.

Another place in Germany where there has recently been hot conflict between sickness societies and doctors is Halle. The societies were not prepared to concede the demands of the organised doctors, which included, among other matters, free choice of doctor. The organised doctors boycotted the societies. The latter imported doctors, some of them apparently not very satisfactory persons. Appeal was made to the supervisory authority that the societies were not providing adequate medical service. The authority decided against the societies, and considered that there should be not less than one general practitioner to every 1,500 members, and made a contract over the head of the societies with the organised doctors, which provided, among other matters, for free choice.

Particulars of the average expenditure per member in two Cologne district sickness societies.

A. Medical service.
B. Medical and surgical requirements.
C. Hospital benefit.
D. Money sickness benefit.
E. Total average expenditure per member.

(The figures *in italics* are those for years when the compulsory medical arrangements were in force.)

(1) *District Society for various Employees (Cologne, Miscellaneous).*

Year.	(A)	(B)	(C)	(D)	(E)
	s. d.	s. d.	s. d.	s. d.	s. d.
1903	2 11	3 7	5 4	11 0	27 6
1906	*5 2*	*5 6*	*4 2*	*13 2*	*32 9*
1908	*5 3*	*5 6*	*6 3*	*14 9*	*37 0*
1910	5 3	4 8	5 5	11 11	33 3

(2) *Combined District Society for Craftsmen.*

Year.	(A)	(B)	(C)	(D)	(E)[1]
	s. d.	s. d.	s. d.	s. d.	s. d.
1903	5 5	3 3	4 8	13 10	31 0
1906	*8 4*	*4 9*	*4 8*	*16 4*	*38 2*
1908	*8 0*	*5 4*	*6 10*	*20 4*	*45 8*
1910	8 11	4 2	7 2	15 1	41 4

[1] There is excluded from the "total expenditure" of each year for this society some miscellaneous expenditure, which amounted in 1910 to an average expenditure of 1s. 1d. per member.

APPENDIX V

DISTRICT SICKNESS SOCIETY FOR LEIPSIC AND NEIGHBOURHOOD

Extracts from the Medical Agreements &c., and from the Medical Regulations of the Society

I. Agreement with the District Medical Associations (p. 247)
II. Contract with General Practitioners (p. 251)
III. Contract with Specialists (p. 254)
IV. Provisions with regard to Committees (p. 255)
V. Regulations for Medical Practitioners (p. 261)

I

Agreement between The District Sickness Society for Leipsic and Neighbourhood *AND* The District Medical Associations of Leipsic Town and Leipsic Rural District.

1. Every independent medical man who practises in the town of Leipsic or in the district of the Leipsic *Amtshauptmannschaft*[1] may, in principle, participate in the medical service of the District Sickness Society for Leipsic and neighbourhood.

   Notice of the wish to participate in the medical service is to be given in writing to the chairman of the Representative Medical Committee,[2] and is to be communicated by him immediately to the society.

   The admission to medical service is to be effected by means of a special contract made between the society and each particular doctor in accordance with the enclosure marked A. . . .

2. The members of the society have choice, in each case of sickness, among the doctors in the service of the society.

[1] See note on p. 115.

[2] "Confidential Committee" is the more literal translation of the German original.

Members are not in any way to be influenced, in making this choice, by the committee or officials of the society. Each member is to be furnished with a list of all the doctors, showing their names, addresses, surgery hours, and speciality, if any, and this list is to be renewed every January.

An addendum to the list is to be issued every July showing any changes notified to the society.

3. The contracts made with salaried society doctors before the making of this agreement are not to be affected by it. On the expiration of a contract, further service is to be arranged only according to the terms of sec. 1 of this agreement.

It is forbidden to make any arrangements conflicting with this agreement during the time it remains in force. But the hitherto existing special provisions with regard to treatment in polyclinics shall be operative.

4. The number of doctors in the service of the society shall not fall below 250, inclusive of specialists but exclusive of dental surgeons.

5. The Representative Medical Committee shall receive, in payment for the services of all doctors who have entered into agreement with the society in accordance with section 1. capitation payments calculated as follows, which payments shall be made at the beginning of each quarter and shall be calculated on the average of the monthly census of the members of the society for the previous year—

(*a*) If medical treatment is restricted to the member himself, 5s. per member per year ;

(*b*) If medical treatment is provided for the dependants of a member as well as the member himself—

7s. 3d. per member per year in the years 1911, 1912 and 1913 ;

7s. 6d. per member per year in the years 1914, 1915 and 1916.

There will also be paid the sum of £200 per annum provided by the Council of Leipsic Town in order that medical treatment may be extended to foster-children who are not mainly maintained by their mothers but whose mothers are, at the time of the medical treatment, members of the society.

In addition to these capitation payments, the society will pay quarterly, midwifery fees, mileage money, and for the

giving of sanctioned electro-physical treatment, as well as the cost of postage, &c.

6. In calculating the amount of the capitation payment, account is to be taken, from the quarter day next following, of any extraordinary changes in the number of members, such as by the division of the society, by the incorporation of other societies, or by change in the area of the society or of the classes of insured persons. If there should be any substantial changes through alterations of the insurance law or of the regulations of the society, new agreements shall be made in regard to the changes.
7. Every society doctor has quarterly to send in an account of his services, calculated according to the lowest state tariff of medical charges with the additions or changes therein agreed upon between the Representative Medical Committee and the society. The account has to be sent in not later than the 15th of the first month of each quarter, and, after having been dealt with at the office of the society, has to be examined by the Representative Medical Committee.

   The Representative Committee shall quarterly divide the amounts of the capitation payments between the several society doctors in proportion to the amounts of their accounts calculated as above. The society shall pay the amounts due to doctors remunerated by salaries according to already existing agreements (sec. 3), and these amounts shall not be deducted from the capitation payments. Payments of amounts due to society doctors (other than the salaried doctors) in addition to the capitation payments shall also be made through the Representative Medical Committee after audit and determination by the society, except payments for treatment in private clinics and for certificates in accident cases.

   The Representative Medical Committee shall retain 2 per cent. of the amount of the capitation payments for meeting their material and personal expenses.
8. The completion of a contract (sec. 1) binds the doctor to give the necessary treatment in every way according to the provisions of the medical regulations, to persons who, according to the rules of the society, have a right to treatment, except in so far as the doctor is personally prevented by absence, sickness, pressing business, and the like.
9. If in any part of the area covered by the society there should be a lack, having regard to the distances, of facilities for average

medical care, the society have the right when a new doctor is admitted to its service, to make it a condition that he shall reside in that part of the area. In such a case the opinion of the Representative Medical Committee has to be heard, and if the committee does not admit the need of such a condition, the matter shall be settled by the Arbitration Committee.

10. The individual contracts can be determined by three months' notice. . . . Notice can only be given by the society on weighty grounds, and appeal may be made by the doctor concerned to the Arbitration Committee. The notice is not to take effect pending the decision of the appeal.

    Notice cannot be given by either party if the total number of doctors does not reach the number set out in sec. 4. . . .

11. The provisions contained in the enclosure B and the fundamental decisions of the Arbitration Committee which have already been, or may be, issued shall have effect for the establishment and operations of—
    (*a*) a Conciliation Committee,
    (*b*) a Representative Medical Committee.
    (*c*) an Arbitration Committee.

12. If members of the society or their dependants entitled to benefit are received into the private clinics of society doctors, the society shall pay for their maintenance the same rates as to the municipal hospitals ; and for operations shall pay two-fifths of the lowest charges in the medical tariff up to a maximum of 20s. The owner of the clinic shall be entitled to charge the patient, for maintenance, an additional sum up to 3s. for members and 4s. 6d. for dependants per day ; and in case of operations the additional sum which may be necessary to make up the amount of the lowest charges in the medical tariff, but in any case not more than 30s. . . .

    In addition to the payments for maintenance and operations, the society shall pay a special fee of 3s. for every necessary general or local anæsthetic.

    The statements of accounts due to private clinics shall be placed for inspection before the Representative Medical Committee. . . .

13. The establishment of consultation centres is prohibited for the period of this agreement.

14. This agreement shall remain in force until the end of 1916, and shall then continue in force for another year, unless at least three months before that time written notice to determine the agreement has been given by the society or by the District Medical Associations. The notice must be submitted to the Arbitration Committee for the expression of their opinion thereon.

(Signed by

The Chairman of the District Sickness Society for Leipsic and Neighbourhood.

The Chairman of the District Medical Association of Leipsic Town.

The Chairman of the District Medical Association of Leipsic Rural District.)

LEIPSIC, *Dec.* 31, 1910.

II

ENCLOSURE A

The following contract has this day been made between the District Sickness Society for Leipsic and neighbourhood and the general Medical Practitioner, Mr. . . .

1. . . .

2. . . . The doctor shall satisfy himself by scrutiny of the membership book that on the day the medical treatment is given either the sick person or, in the case of dependants, the person on whom they are dependent, within the meaning of the rules of the society, is a member of the society or that, notwithstanding that he is no longer a member, he is entitled to receive benefit from the society. In doubtful cases the doctor shall obtain information from the society. . . .

Medical treatment shall extend to the giving of advice at the surgery of the doctor, to the visiting and treating of patients at their homes, and to the giving of all certificates prescribed in the rules of the society.

In cases of dispute between the society and trade accident associations, properly prepared certificates of the state of

health of a patient shall be made at the request of the society. . . .

3. The undersigned doctor undertakes to visit cases in response to requests made to him up to 9 a.m. or in the course of his morning consultation hours as soon as possible, and in every case on the day when the request is made. In very urgent cases—cases in which there appears to be danger to life, or in which there would be danger in delay—the doctor shall visit the patient forthwith. . . .
4. It is left to the conscientious discretion of the doctor to decide how often he shall visit the patient at his residence, or how often the patient shall come to him for consultation. He must be guided wholly in this matter by the nature of the illness, not by the wishes of the patient or of his family.
5. Special care is to be taken in deciding whether a person who says that he is ill is really ill, and, if he is, whether he is unable to work within the meaning of the insurance law. In general, inability to work will only be present if, according to medical opinion, which is to be based especially on the objective state of health, the patient is unable to continue at the kind of employment in respect of which he is compulsorily insured or to carry on his trade.

   If there is any suspicion of malingering or failure on the part of the sick person or convalescent to comply with the directions of the doctor, written report must immediately be made to the society.
6. The doctor in making his prescriptions shall have as much regard as possible to the cheapness of the drugs and to the facility of dispensing them, in so far as is consistent with the desired cure of the patients, and, if a prescription is repeated, to securing the re-use of bottles, &c.

   The providing of tonics, milk, wine, trusses, spectacles, artificial teeth, elastic stockings, orthopædic and other appliances, &c., as well as of more than two baths, more than three massage treatments, and all electro-physical treatment within the meaning of sec. 9 of this agreement, requires the previous approval of the society, except in urgent cases marked on the prescriptions as such.
7. The conditions contained in the doctors' regulations shall have effect as regards the sending of patients to hospitals.
8. If the doctor is prevented by illness or other cause from

performing his duties, he must forthwith provide one or more doctors, qualified in Germany, to act for him. The society doctor is responsible for the due treatment of patients by the deputy. The treatment of patients must in no case be neglected because of the doctor's inability to act.

9. . . . In case of electro-physical treatment through use of special apparatus as provided in the doctors' regulations, there shall be granted, in addition to the remuneration for consultation included in the capitation payment, the same amount as additional remuneration.

In case of visits to a patient who resides more than one kilometre from the nearest society doctor, according to the *Mittelbach* map, there shall be paid, in addition to the capitation payment, a distance fee of 9d. for every kilometre beyond the first kilometre of distance.

All of the certificates mentioned in sec. 2 of this agreement are to be given without charge, as well as any information required by the society. But repayment may be obtained for cost of postage, &c.

For the accident certificate mentioned in sec. 2, . . . the doctor has a claim to a special fee of from 5s. to 10s., regardless of the capitation payments.

10. It is to be determined at the audit of the Representative Medical Committee, for which provision is made in sec. 7 of the agreement of the 31st Dec., 1910, whether the statement of account submitted by a doctor contains excessive charges or shows failure to give proper attention to the conditions laid down in sec. 5 of this agreement.

In case of excessive charges, the excess is to be placed to the credit of the capitation payments, other than excess in the charges for special fees (midwifery cases, mileage, &c.), which is to be placed to the credit of the society. Objection may be made by the doctor affected against the decision of the Representative Medical Committee within two weeks. The Representative Medical Committee decides definitively on the objection.

In case of any marked contravention of the conditions laid down in sec. 5 of this contract, a fine is to be levied on the doctor in default, because of the additional expense to the society in money benefit in consequence of the default. This fine is to be determined by the Representative Medical Committee. The amount is to be deducted

from the sum payable to the doctor as remuneration and is to be handed over to the society. The doctor may, within four weeks, appeal to the Arbitration Committee against such a decision.

The checking of prescriptions shall extend to the question whether the conditions of sec. 6 of this contract have been fulfilled. The conditions of the foregoing paragraph shall also have effect with regard to the checking of prescriptions.

In so far as the total amount of the sums claimed by doctors in their statements of account exceeds the total amount of the capitation payments to be made, the sums paid to the several doctors shall be proportionately reduced.

11. The doctor shall carefully observe the provisions of the regulations relating to doctors.

III

The following contract has this day been made between the District Sickness Society for Leipsic and neighbourhood, and Mr. . . . , specialist for . . .

1. The society agrees to allow treatment by the undersigned doctor to be given in a private clinic, licensed by the State, to members and dependants entitled to free medical treatment at the cost of the society.
2. The Sickness Society undertakes to pay, towards the cost of maintenance, 2s. a day in respect of every member, and 6d. a day in respect of every dependant of a member (sec. 1) treated in a private clinic.

   The amount to be required of a patient himself or his family in respect of his treatment or that of a dependant is not to exceed 3s. a day when the member himself is treated, or 4s. 6d. a day when a dependant is treated. This restriction is not to apply to persons who consent to be received as private patients. . . .
3. Special charge is not to be made in respect of an operation to a society patient (sec. 1) for which the lowest charge in the medical tariff is less than 3s. The society will pay to the

treating doctor, in respect of any other operation, two-fifths of the lowest charge in the State medical tariff: the other three-fifths is to be obtained from the patient (or his family). If the charge for an operation in the lowest rates of the medical tariff exceeds 50s., the amount to be charged shall be reduced, both to the society and to the member (or his family) to 50s., but the full amount of the lowest rates may be charged in respect of other operations. This restriction is not to apply to persons who consent to be received as private patients.

In addition to the payments for maintenance and operations, the society will pay 3s. for every necessary general or local anæsthetic.

4. The conditions of sec. 3 shall also have effect in cases in which the operation has been performed in a private clinic and the patient did not require to be nursed or detained in the clinic.
5. The amounts to be paid by the society for maintenance (2s. a day for a member; 6d. a day for a dependant) and for operations shall be wholly additional to the capitation payments.
6. The medical treatment in the private clinic of patients on whom operations have been performed is to be undertaken free of extra cost.

Medicines, tonics, dressings, chloroform and other similar requirements needed for treatment are to be provided by the clinic for patients treated therein as members of the society, and extra charge is not to be made for them either to the society or to the patient.

7. . . .
8. . . .
9. . . .

IV

Enclosure B

Provisions with regard to the Representative Medical Committee, the Conciliation Committee, and the Arbitration Committee, of the District Sickness Society for Leipsic and Neighbourhood.

In connection with the society and in accordance with sec. 11 of the agreement made on the 31st Dec., 1910, between the

society and the District Medical Associations of Leipsic Town and Leipsic Rural District and for the period of operation of that agreement, the following shall be established—

1. A Representative Medical Committee of the society doctors,
2. a Conciliation Committee, and
3. an Arbitration Committee,

and the following provisions shall apply to the establishment and operations of these Committees.

A.—*The Representative Medical Committee of the Society Doctors.*

1. The Committee shall consist of twelve members, who shall be chosen every two years by the doctors in the service of the society in accordance with secs. 1 and 3 of the agreement of the 31st December, 1910, and from among themselves.
2. The election . . . shall be made by ballot. . . . Four deputy members shall be elected at the same time to take the place of members who cease to hold office. . . .
3. . . .
4. A quorum of the committee shall consist of the chairman or the vice-chairman, and not less than six members. . . .
5. The committee shall be called together by the chairman at his discretion. Meetings shall be held with sufficient frequency for the settlement of urgent cases, where possible, within a week. . . .
6. . . . If requested, the society shall provide a suitable room on its premises for meetings of the committee.
7. . . . In work involving much clerical labour, the society shall provide the committee with clerical assistance free of cost, if required by the committee.
8. The duties of the committee shall relate primarily to the constant supervision and control of the work of the society doctors, also to calculating and dividing the remuneration of the doctors, and to the maintenance of their rights and interests. . . .
9. The committee shall control the proceedings of the society doctors as regards—
   (*a*) all the accounts of the doctors, after they have been checked, so far as the figures are concerned, at the office of the society. The committee shall see that the charges are right and reasonable. Amounts in excess of what should be charged shall be deducted . . .;

(*b*) the prescriptions of the doctors for drugs and other medical or surgical requirements, tonics, baths, and the like. The committee shall see, after audit of the figures and statistical preparation by the society, that the prescriptions are economical, that they are within the limits fixed, that proper provision is made for the re-use of bottles, etc. They shall object to the use of secret remedies, and shall deduct from the remuneration of the doctor, for the benefit of the society, the amount of charges which should not have been incurred . . . ;

(*c*) the number of persons certified by each doctor as unable to work, and the length of time of the inability, according to statistics prepared by the society. They shall determine where there has been improper excess of the normal average. In case of serious default as regards certifying patients as unable to work . . . the committee shall deduct from the remuneration of the doctor, for the benefit of the society, the excess charges incurred, in consequence of the default, in payment of benefit. . . .

(*d*) The committee shall communicate half-yearly to all the society doctors the results of the statistical preparations to which reference is made above.

10. If in dealing with matters under sec. 9 it has been found that a doctor has been seriously at fault, the committee may take one of the following actions, in addition to making the deductions from the doctor's remuneration—

(*a*) advice ;

(*b*) written warning ;

(*c*) after two unheeded warnings, temporary suspension, for from one to twelve months, from attendance on society patients.

Before measures are taken under (*b*) or (*c*), the doctor concerned must be heard.

If a doctor has been twice temporarily excluded from society practice without result, and if the society does not exercise its right to give the doctor notice to terminate his contract, the committee may make a request to the Arbitration Committee that the doctor be permanently excluded from society practice.

11. Complaints made by a patient or by the society with regard to the practice of a doctor are to be brought before

the Representative Medical Committee for its opinion. Steps shall be taken by the committee in accordance with the provisions of section 10. The opinion given on the case shall be communicated to the doctor by the committee.

The rights of the society with regard to giving notice to terminate a contract . . . shall not be affected by any action taken under this section.

12. The chairmen of the District Medical Associations, as well as the committee of the society, are to be informed of any action taken under section 10 (*b*) and (*c*) or section 11. . . .

13. The society shall promptly prepare for the committee all the information (cf. sec. 9) necessary for the duties imposed upon it by the foregoing sections. The society shall also furnish to the committee within a week any other information required.

The committee shall be immediately informed of any change of doctors in the service of the society.

14. If the powers of the committee are limited in any contract with a particular doctor, the limitations shall have effect. So also shall have effect the conditions contained in the agreement of the 31st Dec., 1910, or those made in the doctors' regulations.

15. Circulars and directions which the society proposes to issue to their doctors are first to be submitted to the committee for their opinion.

Complaints by a doctor against the society have first to be communicated to the committee, which has to give an opinion to the doctor on the complaint. This opinion shall be communicated to the society. Complaints by doctors with regard to members of the society are to be communicated to the committee only if the managing committee of the society does not give satisfaction to the doctor in regard to the complaints.

B.—*The Conciliation Committee*

16. The special Conciliation Committee shall be appointed for deliberation on questions which appear to require consultation between the society and its doctors, and for the friendly consideration of all kinds of differences. This committee shall consist of the two chairmen, the two deputy chairmen, and one member each, to be chosen for a year,

of the managing committee of the Sickness Society and of the Representative Medical Committee.

The deputy chairmen shall act as deputies for the chairmen. Persons specially appointed for the purpose, and for the same term of office, shall act as deputies for the deputy chairmen and for the other members.

17. The Conciliation Committee shall be summoned by the two chairmen, even if only one of the chairmen shall require it. . . . The chairmanship shall rest alternately with the chairman of the managing committee of the society (or his deputy), and the chairman of the Representative Medical Committee (or his deputy), the former being chairman at the first meeting. Resolutions shall be valid only if all (6) members (or their respective deputies) are present, and if at least four votes are cast for them.

The secretarial work of the committee shall be done by an official of the Sickness Society, if the committee does not appoint one of its own members for the work.

C.—*The Arbitration Committee*

18. The Arbitration Committee shall be composed of nine members.

The chairman of the managing committee of the Sickness Society, the deputy chairman, and one other member of the managing committee chosen by the committee for a year, shall be members of the Arbitration Committee. Three other members of the managing committee shall be chosen to act in case any of the previous three are prevented from doing so.

The chairmen of (1) the District Medical Association of Leipsic Town, (2) the District Medical Association of Leipsic Rural District, (3) the Representative Medical Committee, shall also be members of the committee. Each of these shall be represented by his deputy chairman if the chairman is prevented from acting.

To these six representatives of the society and of the doctors shall be added two members of the Royal *Kreishauptmannschaft* and the medical councillor of that authority.

The material expenses of the Arbitration Committee

shall be borne (*a*) by the doctor whose appeal is being considered, if his appeal is not upheld ; (*b*) if his appeal is upheld, by the two doctors' associations and by the society in equal shares.

19. The Arbitration Committee meets on the invitation of the Royal *Kreishauptmannschaft* on their premises. A member of the *Kreishauptmannschaft* shall be chairman. Five members shall be a quorum. Resolutions shall be valid if passed by a majority of the members voting. If the votes are equal, the chairman shall have a casting vote.

20. The Arbitration Committee shall decide definitively on matters referred to it in accordance with the agreement of the 31st Dec., 1910, or in accordance with individual agreements made with the doctors, or on such matters as may in future be referred to it ; also on appeals against measures taken by the Representative Medical Committee under secs. 10 (*b*) and (*c*) and 11 ; further, on any proposal for the permanent exclusion of a doctor, or for any change of the present stipulations (sec. 10, part 2 ; sec. 24). In addition, the committee shall decide definitively on differences in the interpretation of the various provisions of the agreement of the 31st Dec., 1910, or of the agreements made with individual doctors, or of these conditions. The ordinary courts of law shall decide disputes which may arise in regard to the remuneration and claims of those doctors who are employed at fixed salaries. Further, the conditions laid down in sec. 14, part 1, of this agreement shall also apply to the Arbitration Committee.

The Arbitration Committee may decide to make its decisions public, but not decisions which touch the failure of duty or other personal circumstances of a doctor, or which, if published, would touch the interests of a third person. . . .

21, 22. . . .

23. All appeals to the Arbitration Committee, to prevent their being excluded, shall be made to the chairman of the committee within four weeks after the decision against which appeal is made has been communicated to the doctor.

24. If during the continuance of the agreement of the 31st Dec., 1910, there should be need of addition to, or any change of,

the foregoing conditions, and the parties to the agreement fail to come to an understanding thereon, the Arbitration Committee shall decide the matter and also the time when the change shall come into force.

(Signed by

The Chairman of the District Sickness Society for Leipsic and Neighbourhood.

The Chairman of the District Medical Association of Leipsic Town.

The Chairman of the District Medical Association of Leipsic Rural District.)

LEIPSIC, 31*st December*, 1910.

V

EXTRACT FROM THE REGULATIONS RELATING TO MEDICAL PRACTITIONERS OF THE DISTRICT SICKNESS SOCIETY FOR LEIPSIC AND NEIGHBOURHOOD

THE Representative Medical Committee has to take notice, not only of contraventions of the terms of the agreement itself, but also of the regulations relating to doctors.

Medical Treatment

If it is not clear from the membership book that the insurance contributions have been paid in respect of the person up to the date on which medical assistance is sought, or if the receipted membership book cannot be produced, the doctor shall give to the person requesting treatment such primary treatment as may be necessary, if there is any danger in delay, but any further treatment, especially the giving of a prescription or a sickness book, shall be expressly contingent on the production of receipts in the membership book.

The treating doctor shall enter in the sickness card of the membership book the date of every first consultation, and, if possible, the date of every last consultation (or visit). Medical attendants at polyclinics shall do likewise.

Change of Doctor

Patients may change their doctor in the course of an illness only with the consent of the society. The society shall not exercise any influence in the choice of doctor, and, if a change of doctor is approved, shall at once inform the doctor changed, with a statement of the reasons for the approval, according to the provisions of these regulations. The sending of a patient by one doctor to another society doctor does not require the approval of the society, but the change must be noted in the membership book and, if the patient is unable to follow his employment, in the sickness book.

The following rules shall apply to the granting or refusal of approval of a change of doctor.—

1. Approval shall be given to the change of doctor by a member or a dependant—
   (*a*) if the society doctor refuses to continue the treatment of a patient and does not send him to another doctor or if the patient does not wish to go to a proposed doctor ;
   (*b*) if the patient cannot be required to retain the same doctor because of the change of address of the doctor or of the patient, or of a change in the consultation hours ;
   (*c*) if the doctor who has given the first attendance in the case of an illness resides so far away, or his consultation hours are so inconvenient, that there would be undue difficulties to the patient in being attended by him ;
   (*d*) if the contemplated change is from a general practitioner to a specialist, or from a specialist to a general practitioner ;
   (*e*) if change of treatment is contemplated, more particularly when the doctor advises a course of treatment or an operation which the patient rejects ;
   (*f*) if the deputy of the treating doctor does not possess the confidence of the patient ;
   (*g*) if the treatment has continued for a long time without apparent result (to give ease of mind to the patient).
2. In addition, change of doctor shall be approved in the case of members who continue at work and of dependants—
   (*a*) in case of differences between the doctor and the patient (in order to prevent further difficulties) ;
   (*b*) in all other cases in which the foregoing conditions seem to exist. (In doubtful cases, the approval shall only be

given after enquiry has been made of the treating doctor, and, in suitable circumstances, also only after a certificate has been obtained from a confidential medical adviser.)

3. Approval to change of doctor shall be refused—
   (*a*) if the patient is not satisfied with the prescriptions of the doctor, or if he desires particular drugs or other means of cure ;
   (*b*) if the patient has made improper proposals to the doctor ;
   (*c*) in the absence of any adequate reasons.
4. In addition, approval to change of doctor shall be refused in the case of members who cannot follow their employments—
   (*a*) if there is suspicion of malingering ;
   (*b*) while examination by a confidential medical adviser is pending ;
   (*c*) in case of dispute with the doctor as regards inability to follow employment. (In these cases the patient shall be speedily examined by a confidential medical adviser. The result of the examination shall be immediately communicated to the treating doctor. If the result agrees with the diagnosis of the latter, the refusal to a change of doctor shall hold good. Otherwise approval is to be given to the change. . . .)

The following cases are not considered to constitute a change of doctor and do not require approval—

(*a*) if at the commencement of an illness, notwithstanding repeated requests, the doctor does not attend and the patient goes to another doctor ;
(*b*) if a patient, in consequence of a sudden change in his condition and inability to obtain readily the services of the treating doctor, obtains the services, for the time, of another doctor ;
(*c*) if a doctor discharges a patient from his care as cured and the latter still considers himself ill. (If a patient in such a case is certified as unable to follow his employment by the new doctor, he shall forthwith after receipt of his sickness book be examined by a confidential medical adviser.)

The Sending of Patients to Hospital

The doctor shall send sick members to hospitals, &c. (even against the will of the member in the circumstances set out in sec. 12, part 3, of the rules of the society) in cases of—

1. illnesses which require long surgical attention or serious operations ;
2. illnesses of all kinds when, because of the conditions of the dwelling-place and the like, treatment in a hospital is desirable ;
3. infectious venereal diseases, especially if the patient is unable to follow his employment ;
4. enteric fever, cholera, smallpox, scarlet fever, diphtheria, epidemic cerebro-spinal fever ;
5. suspicion of malingering ;
6. request of the managing committee of the society.

Members who, according to sec. 12, part 3, of the rules of the society, have the right to refuse hospital treatment may be treated in their homes, after the advantages of hospital treatment have been repeatedly brought to their notice. Since patients who have not the right to refuse hospital treatment lose their claim to money benefit in case of refusal, the doctor must forthwith report to the society any such case of refusal.

Members who are declared able to follow their employment but who assert that they are still unable to do so are as a rule to be sent to hospital for observation if they so desire.

Request for reception into a hospital has to be made as a rule to the administration of the society. As an exception members may be sent directly to a hospital when there is danger in delay, as at times when the offices of the society are closed. The necessity for conveying the patient by ambulance or carriage is to be indicated on the certificate.

Dependants of members cannot compulsorily be sent to a hospital, but, in circumstances such as those mentioned above, the doctor shall also in these cases endeavour to persuade such patients to go to a hospital.

When patients are recommended to go to a private clinic, they shall be informed that treatment in a public institution is without charge to them, but that they have, as a rule, to pay (in part) for treatment in a private institution.

Certification of Inability to follow Employment

Care is to be exercised in determining the first day when the patient is able to resume work, and, in doing this, account is not to be taken of the first day of the week, but the first day shall be certified which succeeds the last day of inability to follow employment, even when the day is a Sunday or a holiday.

Sickness Book

A Sickness Book is to be given to a sick member when he becomes unable to follow his employment.

The day on which the doctor first establishes that there is inability to follow employment is to be entered as the day of notification. If the patient declares that he was unable to follow employment before the day on which medical treatment is received, this fact is to be entered among the remarks.

Patients are not to be allowed unlimited time for going out of doors. The time allowed for going out is to be, as a rule, as follows : in the months—

Nov., Dec., Jan., Feb.,	not more than	5	hrs.,	and	latest	up to	5	p.m.
Mar., Apl., Sep., Oct.,	„	„	6	„	„	„	6	„
May, June, July, Aug.,	„	„	7	„	„	„	8	„

If these limits are exceeded, the sickness society may restrict the time of going out as provided above, after receiving a certificate from a confidential medical adviser, according to the nature of the sickness or having regard to the character of the patient. The treating doctor is immediately to be acquainted with any action so taken by the society. If the doctor raises objection, the provisions of the regulations relating to doctors respecting control enquiries shall have effect. The restrictions made by the society shall remain in force until the matter is decided.

If there is any suspicion of malingering, the patient shall as a rule not be allowed to go out, at least not beyond the visiting of the doctor during his consultation times ; in suitable cases, the patient is to be ordered to remain in bed.

In recording diagnosis, general indications are to be avoided as much as possible—for example, recording simply lead poisoning, nervous disease, stomach trouble, throat trouble, kidney disease, abdominal complaint, venereal disease. Occupational accidents are to be indicated as such.

During the continuance of inability to work, the doctor shall give to the patient, after examination, a certificate of sickness at the end of every week, as a rule not before Friday.

Maintenance in the Country and in Convalescent Homes

Applications for maintenance in rural or bath establishments, as well as the allowing of patients to go to their homes when

these are outside the area covered by the society, and also for reception into the convalescent homes, are to be made to the society only after most careful examination and when genuine inability to follow employment exists.

Patients suffering from the following diseases are to be wholly excluded from the convalescent homes—tuberculosis, other infectious or offensive diseases, mental disease, alcoholism, epilepsy. Pregnant women are also not to be admitted. Consideration is not to be given to persons who wish to use the convalescent homes as places of recreation free of cost during holiday time or temporary unemployment.

Applications for Curative Treatment through the Invalidity Insurance Authority

Insured persons may receive treatment at the cost of the Invalidity Insurance Authority for the Kingdom of Saxony in sanatoria for lung complaints or, according to the nature of their illness, in other sanatoria or in bath establishments, if—

(*a*) treatment is necessary for an illness which may be expected (without special treatment) to produce invalidity ;

(*b*) there is expectation that by proper treatment the person may be wholly cured or at least markedly and lastingly improved so that the threatening invalidity will be prevented and the insured person will be able to continue at his employment for years.

The treating doctor has to fill in the application form which may be obtained of the Sickness Society and to forward it to the society through the patient. If the Invalidity Insurance Authority accepts the application, it will send to the treating doctor a form of queries, for filling up which it will pay 6s. at the close of the year.

Control Enquiries

The time and place of the control enquiries respecting patients unable to follow their employment will be communicated to the treating doctor beforehand, and it is permitted to him to attend. If he, the treating doctor, does not agree with the results of the enquiry and is not satisfied with the action taken by the society, he shall inform the latter of the grounds of his objections. If an agreement cannot be reached between the confidential medical adviser and the

treating doctor, the patient shall be sent by the society to a medical arbitrator, whose decision shall be final. These arbitrators shall be annually appointed by the committee of the society in agreement with the Representative Medical Committee, and an arbitrator and a deputy shall be appointed for each speciality in which question may arise.

The services of the arbitrator may also be requisitioned by the society in cases in which a member who has been certified able to work strongly declares his inability, and this notwithstanding that the treating doctor and the confidential medical adviser agree on the case.

APPENDIX VI

MUNICH: MEDICAL ARRANGEMENTS OF THE DISTRICT SICKNESS SOCIETY

THE society has an agreement with the Munich Doctors' Association for the Free Choice of Doctor. This association is a voluntary organisation specially formed for the purpose of dealing with sickness societies. Any qualified doctor may belong to it—provided that he has been in independent practice in the district for not less than two years.

Every member of the doctors' association undertakes to give treatment to insured members in accordance with the terms of the agreement. Separate contracts are not made with individual doctors.

The agreement provides, among other things, for—

1. Free choice among the doctors of the association (and among the university clinics) in each case of sickness. Free choice is also given to members among the hospitals, &c., which have an agreement with the society and are on the list of the doctors' association.
2. Payment of a capitation fee, and the division of the proceeds among the doctors according to services rendered. For this purpose, a consultation at the surgery in the day-time counts one point, at night-time two points; and consultation at the house of the patient counts two points.
3. Payments for special medical or surgical services according to an agreed list. The list contains no less than 146 kinds of services, most of them being operations. The highest fee is 50s., which is paid, for instance, for removal of cataract and for Caesarean section on the living. Mileage money is paid in certain circumstances.
4. The appointment of five committees for regulating the relations between the society and the doctors—

(*a*) Conciliation Committee.

This consists of three representatives of the society and three representatives of the doctors' association, chosen annually, together with the director (business manager) of the society and the director of the association. The chair is taken alternately by one of the representatives from each side. The committee settles disputes. Appeal lies to the Arbitration Committee, but only when the voting in the Conciliation Committee is equal or when not less than two members of the latter support the appeal.

(*b*) Arbitration Committee.

This likewise consists of three representatives of each side, with a jurist as independent chairman. Its decision is final in cases referred to it. In both Conciliation and Arbitration Committees, decision is by a majority of votes. The chairman of the latter committee has a casting vote.

(*c*) Remuneration Control Committee.

This consists of twenty members, all doctors—ten general practitioners and ten specialists. A general practitioner is chosen as chairman. The committee checks the claims for remuneration. It is its business to prevent improper charges. Some of the operations for which special payment is provided can only be performed at the cost of the society with the express consent of this committee. The committee may levy fines on the doctors.

(*d*) Prescriptions Committee.

This committee consists of fourteen members (doctors). It has annually to choose four members who are to look through the prescriptions to see that they are made with due regard to economy. These four members receive payment for their services. Confidential medical advisers or pharmacists employed by the society are to participate in the meetings of the committee.

(*e*) Sickness Control Committee.[1]

This consists of thirty-six members. The committee has to deal with questions relating to the medical control of persons suspected to be unfairly a charge on the funds of the sickness society. The committee may levy fines on the doctors.

[1] For some details as to control, see pp. 119–20.

The society in addition employs confidential medical advisers. The persons so chosen must be members of the Doctors' Association for Free Choice of Doctor. The Association has the right to make proposals in the appointment of confidential advisers. If a suitable member of the association cannot be obtained as confidential adviser, the society has the right to make an appointment from outside the association.

It is provided that 4 per cent. of the payments made by the society for medical service shall be deducted to meet the expenses of administration of the association and for philanthropic purposes, &c.

APPENDIX VII

FRANKFORT-ON-MAIN: MEDICAL ARRANGEMENTS

THE agreement between the federation of sickness societies in Frankfort and the local medical association for free choice of doctor, which had been in force for five years, was renewed in 1910 for a further period of five years, with modifications.

The federation contains in all thirty-seven societies, and includes district societies—of which the largest is the general district society, with nearly 100,000 members—establishment and guild societies, and some voluntary aid (friendly) societies.

The main provisions of the agreement are as follows—

1. There is to be free choice of doctor among those belonging to the association.

   The doctors are bound to give treatment to members of the federated societies, unless the patient lives more than one kilometre from the doctor's residence, when attendance by the doctor is optional. If no doctor who is a member of the association resides within a kilometre of the patient's residence, the nearest doctor is bound to attend if requested.

   A member is not allowed to change his doctor during an illness and within a period of three months, except with the consent of his society, which is only given for special reasons.

   It is provided that, if the number of doctors, exclusive of specialists, falls below the proportion of one to every 1200 of the members of the federated societies, the federation may terminate the agreement.

   The responsibility for proper treatment is placed on the individual practitioners, not on the association. But in case of default, the compensation to be paid to the injured society is determined by the Conciliation Committee, or failing them by the Arbitration Committee (see 3 below). The doctors' association also has a general responsibility to see that its members carry out their duties properly.

New doctors are not to be admitted to practice until six months after their application. In the course of three of the six months, they must attend meetings of the confidential medical advisers and of the Prescriptions Committee (see 3 below) so as to become acquainted with the work of the society—a suggestive provision.

The societies may allow members to be attended by homœopaths or qualified doctors giving nature treatment, on the same conditions as doctors who are members of the association.

2. Terms of remuneration are fixed.

Payment is by capitation fee, except in the case of one society, with apparently a higher class membership than usual. The amount of the annual capitation fee per member is 4s. 6d. in the case of establishment and trade societies ; [1] 4s. 2½d. in the case of the other societies.[2] But, in the case of the general district society, if the finances of the society exceed a stated standard of prosperity, the fee is to be 4s. 6d.

For treatment of the family of a member the capitation fee is to be 9s. 6d. a year. But a family with an income exceeding £100 per annum is not to be admitted on these terms.

The amount of the capitation fees are to be paid quarterly, and are to be calculated on the number of members on the fifteenth day of the second month of each quarter. The amounts are to be paid to the association for division among the doctors.

Special fees, additional to the capitation payments, are to be paid for midwifery cases (where there are special circumstances necessitating medical attendance : an ordinary confinement does not entitle a member to medical benefit) and administration of anæsthetics.

3. Special arrangements are made for control.

(*a*) If an insured person has a complaint to make against a doctor, he makes it to his society. The society communicates with the doctor. Failing satisfaction, the society

[1] Formerly—1905–7, 4s. ; 1908–9, 4s. 2½d.

[2] Formerly—general district society, 4s. (1905–7), 4s. 2½d. (1908–9) ; others from 3s. 9d. to 3s. 11½d.

may refer the matter to the association. If a doctor has a complaint against a society, he makes it through his association.

(*b*) Prescriptions Committee.

This is a committee of the medical association. Its business is to examine the prescriptions of doctors, to see, for instance, that they are made with due regard to economy, and that the articles ordered are within the limits fixed. Under certain conditions, a deduction may be made from the remuneration payable to a doctor if he has been lax in his prescriptions.

(*c*) Conciliation Committee.

This committee is composed of three representatives of the federation and three of the association. Disputes are referred to it. Decisions to be valid must be supported by each group of representatives. Failing decision, appeal lies to the Arbitration Committee.

(*d*) Arbitration Committee.

This committee is also composed of three representatives of each side, but not the same persons as sit on the Conciliation Committee. The committee is the court of appeal. Failing agreement on a question, the matter is referred to an umpire. The latter is chosen by the members of the committee. If they cannot agree, he is chosen by lot.

(*e*) Confidential Medical Advisers.

These are to be appointed by the federation, from members of the association, after consultation with the latter. It is contemplated that a number shall be appointed each with specialist knowledge. They are employed by the federated societies for part only of their time and are paid by fees. They examine patients for the purpose of control and when special treatment is recommended, &c. They may also be required to examine applicants for voluntary insurance in the general district society. Their duties, terms of office, &c., are to be settled between the federation and the association.

In certain conditions, the societies may appoint persons as confidential medical advisers who are not members of the association. But persons so appointed are to be subject to the regulations of the association.

The agreement also provides that conferences may be arranged between representatives of the societies and members of the association for discussion of matters of common interest, and for consideration of questions of general hygiene, &c.

APPENDIX VIII

STUTTGART: MEDICAL ARRANGEMENTS

FREE choice of doctor has prevailed in Stuttgart since 1900. The agreement between the district sickness societies and the doctors came up for renewal in 1910. The doctors demanded very large increases in rates of remuneration. They did not obtain all that they desired—the societies declared that the demands were beyond their means—but they secured large increases. In the case of two district societies the annual capitation rates per member were raised—

from 4s. to 4s. 2½d., rising by annual increases to 5s. in 1919 in respect of members without dependants; and

from 10s. to 10s. 6d., rising by annual increases to 12s. 6d. in 1919 in respect of members with dependants, with a further rise to 13s. 6d. in 1920 if the funds of the societies are in a sufficiently prosperous condition.

It is stipulated that the annual payments to be made shall not in total exceed 80 per cent. of the amounts which would have had to be paid if the doctors were remunerated for their services in accordance with the minimum rates of the State medical tariff. If the sum total of the capitation payments at the agreed rates should exceed the 80 per cent., it is to be reduced to this limit.

For a third district society, with more highly remunerated members than the other two, the doctors are to receive 5s. a year in respect of each member without dependants, and 15s. for each member with dependants. It was estimated that this would yield about 85 per cent. of what would be paid under the minimum rates of the State tariff.

The doctors demanded that for members with incomes above £100 per annum they should be remunerated at the minimum scale of the State tariff. But the societies contended that they

could not legally thus divide their members into two classes for the purposes of medical remuneration.

The agreement provides that special remuneration, additional to the capitation payment, shall be given for certain services—midwifery cases; surgery attendances or visits at night; urgent visits; special consultations; extraction of teeth: mileage money is also paid in certain cases.

The local federation of district societies—the agreement was made between the federation and the doctors' association—is annually to produce statistics which will show, in the case of each doctor—

the expenditure per person on (i) drugs; (ii) alcohol; (iii) baths, electrical treatment and the like; (iv) spectacles, trusses, &c.; and (v) nourishment: and the number of days of inability to follow employment per member treated.

Obviously these statistics afford valuable material for control.

Committees are provided for the purpose of exercising control and for settling disputes.

APPENDIX IX

PARTICULARS RESPECTING SOME DISTRICT SICKNESS SOCIETIES OF GERMANY: YEAR, 1910.

A. Name of Society.
B. Average membership.
C. Percentage of wages deducted as contributions.
D. „ „ paid in money benefit.
E. In case of treatment in hospital—percentage of ordinary benefit (D) paid to dependants as money benefit.
F. In case of treatment in hospital—proportion of ordinary benefit (D) paid as money benefit to member without dependants.
G. Waiting period before money benefit paid.
H. Period of benefit.
I. Whether maintenance provided in convalescent homes.
J. „ „ „ day convalescent resorts.
K. Benefit to dependants—whether medical attendance given.
L. „ „ „ drugs provided.
M. Additional contribution, if any, per member per month, for benefit to dependants.
N. Whether benefit paid in respect of death of wife of insured member.
O. „ „ „ „ children „ „
P. Whether benefit under (N) and (O) given without additional contributions.
Q. Average number, per 1,000 members, of cases of illness with inability to follow employment.
R. Average number of days of sickness per case where member unable to follow employment.
S. Average Expenditure per member on certain items—
   (*a*) Medical service—exclusive of dental treatment when this separately stated (*b*).
   (*b*) Dental treatment.
   (*c*) Medical and surgical requirements.
   (*d*) Treatment in hospitals, &c.,
   (*e*) Money benefit to members.
   (*f*) „ „ for dependants (when member in institution).
   (*g*) Administration—personal (staff).
   (*h*) „ —material.
   (*i*) Total of foregoing items.

(I am indebted for the particulars to one of the Düsseldorf societies.)

A.	B.	C.	D.	E.	F.	G.	H.	I.	J.	K.	L.	M.	N.	O.	P.	Q.	R.	S.								
		Per Cent.	Per Cent.	Per Cent.		Days.	Weeks.										Days.	(a)	(b)	(c)	(d)	(e)	(f)	(g)	(h)	(i)
												s.						s.	s.	s.	s.	s.	s.	s.	s.	s.
Leipsic	182,898	4	55	66⅔	¼	1	34 (a)	yes	yes	yes	yes	—	yes	yes	yes	411	24·7	7·62	0·53	4·37	3·74	14·94	0·95	2·85	0·63	35·63
Munich	125,142	4½	50	50	1/10	3	26	yes	no	no	no	—	no	no	—	537	26·4	6·63	?	3·97	8·03	17·51	0·60	2·77	0·61	40·12
Berlin, business assistants, &c.	119,431	3¾	50	50 & 100 (d)	¼	3	26	yes (b)	no	no	no	—	no	no	—	403	29·2	4·27	0·90	4·47	6·48	17·01	0·62	3·37	0·54	37·66
Dresden	119,419	3½	50	50	nil	3	26	yes	no	yes	no	—	yes	yes	yes	313	27·0	6·36	?	4·38	4·93	10·02	0·59	2·65	0·55	29·48
Frankfort-Main, general	97,750	3⅝	50 & 60	50	1/10	2	26	no	no	yes	yes	1·60	yes	yes	yes	?	17·8	4·86	?	4·44	4·83	19·99	0·61	2·99	0·65	38·37
Barmen, general ...	40,866	3½	50	50	1/10	1	26	yes	no	yes	no	—	yes	no	yes	519	19·4	7·96	?	4·35	3·21	24·41	0·31	1·74	0·43	42·41
Hanover, common ...	37,856	3½	50	50	1/10	3	26	no	yes	yes	yes	1·50	no	no	—	562	20·8	4·98	0·33	3·60	5·46	14·02	0·34	1·98	0·62	31·33
Düsseldorf, common ...	37,440	3 1/10	60	50 & 60 (b)	1/10	3	52 (b)	yes	yes	yes	no	0·65	yes	yes	yes	428	21·0	7·37	0·37	3·18	8·63	11·73	0·97	2·09	0·86	35·20
Pforzheim, general ...	35,436	4	50	50	nil	3	26	no	no	no	—	—	no	no	—	425	22·8	4·79	1·43	3·06	6·14	11·61	?	1·93	0·76	20·72
Mannheim I.	33,332	3⅝	50	50	1/10	3	26	no	yes	no	no	—	yes	yes	yes	530	20·9	6·33	?	4·0	6·55	16·70	0·58	3·17	0·64	37·97
Strassburg, common ...	31,254	4½	50 & 60	50	¼	1	52 (b)	no	no	yes	no	—	yes	yes	yes	671	14·0	4·88	1·07 (h)	1·82	4·36	26·46	?	2·35	0·44	41·38
Cologne, miscellaneous	25,634	4½	60	50	1/10	3	26	no	no	yes	partly (f)	1·00	no	no	—	396	27·4	5·22	?	4·64	5·43	11·35	0·54	2·61	0·64	30·43
Essen, general ...	24,554	3½	62½	50	nil	2	26	yes	no	yes	partly (f)	—	yes	no	yes	613	15·3	5·21	?	3·18	6·11	11·71	0·90	1·19	0·20	28·50
Mainz	21,323	4½	50	50	1/10	2	26	yes	no	yes	no	—	yes	yes	yes	474	20·9	8·89	0·74	3·99	3·51	15·09	3·47	3·12	0·40	39·21
Kiel	20,844	3½	50	50	¼	3	26	no	yes	yes	yes	—	yes	yes	yes	654	?	8·63	?	6·23	3·51	19·74	0·38	2·56	0·47	41·52
Wiesbaden, common ...	17,937	3·85	50 & 60	50	¼	2	26	no	yes	yes	yes	1·50	yes	yes	no	523	24·5	5·56	?	4·24	4·00	16·86	?	2·76	0·73	34·15
Duisburg...	17,741	4·2	50	50	nil	3	26	no	no	yes	yes	—	yes	yes	yes	1078 (g)	14·0	11·14	1·12	11·15	7·61	14·03	0·37	1·85	0·59	47·86
Darmstadt	14,984	3⅜	50 & 60	50	1/10	3	39 (c)	no	yes	no	no	—	no	no	—	441	27·5	4·45	0·95	2·75	3·53	16·46	0·33	2·09	1·03	31·59
Cologne, craftsmen ...	14,276	4½	50	50	1/10	3	26	no	no	yes	no	—	yes	yes	yes	471	23·3	8·89	?	4·14	7·14	14·14	0·97	2·98	0·60	38·86
Remscheid	13,364	3	57	50	1/10	3	26	no	no	yes	no	—	no	no	—	351	19·6	7·54	0·35	3·12	2·23	10·60	0·21	1·44	0·84	26·33
Bochum, general ...	12,627	3·2	50	50	1/10	1	26	no	no	yes	partly (f)	1·50	no	no	—	453	18·9	7·79	?	5·16	4·53	10·81	0 62	2·95	0·99	32·85
Solingen	11,575	3	50	50	nil	3	26	yes	no	no	no	—	no	no	—	400	17·3	5·38	?	5·51	4·07	8·44	?	2·04	2·06	27·50
Crefeld, factory workers	10,370	3	50	50	¼	3	26	no	no	yes	no	—	yes	yes	yes	337	22·4	8·04	?	3·54	3·22	9·37	0·68	1·10	0·56	26·51
Welmar, common ...	8,780	3½	50	50	1/10	1	52 (e)	no	no	yes	yes	—	yes	yes	yes	420	17·2	6·88	0·57	4·86	3·50	7·52	0·73	1·35	0·46	25·87
Düsseldorf, business assistants, &c.	8,759	3⅓	58⅓	50	⅓	3	39 (b)	yes	yes	yes	no	0·65	yes	yes	yes	370	23·0	7·55	?	3·35	8·40	10·58	1·19	2·06	0·75	33·88
Crefeld, craftsmen ...	8,416	3	50	50	1/10	3	26	no	no	no	no	—	no	no	—	320	19·5	5·84	0·18	3·32	3·47	7·97	0·45	1·82	0·19	23·24
Baden-Baden, general...	7.840	4	50	50	nil	3	26	no	no	yes	yes	0·65	no	no	—	268	25·0	6·40	?	5·60	4·55	9·30	0·35	1·79	0·70	28·69
Düsseldorf, Herrdt — Oberkassel, common	2,471	3	50	50	⅛	3	26	no	no	yes	yes	—	yes	yes	yes	531	15·6	9·89	0·66	6·04	7·0	15·42	0·27	2·09	1·85	43·22

(a) After 6 weeks' membership.
(b) „ 26 „ „
(c) „ 52 „ „
(d) 100 after 52 weeks' membership.

(e) Only medical service and drugs provided for so long as 52 weeks.
(f) One-half the cost of drugs paid.
(g) Inclusive apparently of cases in which patient was able to follow employment.
(h) This apparently includes cost of some requirements.

APPENDIX X

COPENHAGEN: REPORT FOR 1909 AND 1910 OF THE FEDERATION OF COPENHAGEN SICKNESS SOCIETIES

THE Federation comprises 67 societies. It has been formed mainly for common counsel. But terms of medical service are arranged through the Federation.

Membership

Particulars are given in the report respecting 66 of the constituent societies. The 66 had over 138,000 members at the end of 1910.

7	societies	had	over	5,000	members	each.	
18	„	„	1,000	or more,	but under	5,000	members.
14	„	„	500	„	„	1,000	„
23	„	„	100	„	„	500	„
4	„	„	under 100	members.			

The three largest societies—the Fremtiden, the Alderströst, and the Fremtids Haab—had 28,515, 15,830, and 13,314 members respectively. The smallest society had but 54 members.

The circumstances of the societies differ very considerably, and in the case of some there are special conditions which explain why the cost of medical service or medical requirements is high.

Contributions

In the year 1910 the average contribution per member was—

15 Kr. (16s. 8d.) or more	...	in 11 societies.
10 Kr. or more, but under 15 Kr.	„	46 „
Under 10 Kr.	„	9 „
		66

(A krone is approximately equivalent to 1s. 1½d.)

The average contribution in the 66 societies was 13 Kr. 70 öre (about 15s. 3d., approximately 3½d. a week). The highest amount was 22 Kr. 16 öre ; the lowest, 5 Kr. 54 öre.

In addition, on the average 4 Kr. 69 öre (about 5s. 3d.) per member was received in State subsidy, and 33 öre (about 4½d.) from various other sources. It has to be borne in mind that the societies further receive a very large amount of assistance from the municipality and the State in the form of reduced charges for hospital treatment (see chapter XVII.).

Expenditure

The average expenditure per member in 1910 was :—

20 Kr. and over	in	10 societies.
15 Kr. and over, but under 20 Kr.	„	44 „
10 „ „ 15 Kr.	„	10 „
Under 10 Kr.	„	2 „
		66

The highest expenditure in any society was 28 Kr. 61 öre, and the lowest 8 Kr. 45 öre. The average in the 66 societies was 17 Kr. 87 öre (19s. 10d.), made up as follows—

4 Kr.	13 öre	on medical service.
2 „	55 „	drugs.
0 „	17 „	dressings, trusses, baths, &c.
1 „	51 „	institutional treatment.
8 Kr.	36 öre.	
0 „	31 „	on confinement benefit.
7 „	59 „	on money benefit.
1 „	61 „	administration.
17 Kr.	87 öre	

Medical Service

The following shows the distribution of the average cost per member of medical service—

Over 10 Kr.	in	1 society.
4 Kr. and over, but under 5 Kr.	„	42 societies.
3 „ „ 4 Kr.	„	20 „
Under 2 Kr.	„	3 „
		66

The society in which the cost was over 10 Kr. (10 Kr. 71 öre) was a society of policemen. The amount seems very high, even when due allowance is made for the fact that the occupation of a policeman, with its exposure to the inclemencies of the weather, and the need therefore of attention to minor ailments, is likely to make the cost of medical service heavy for this class. Payment of remuneration to doctors in this society is according to services rendered, and this is said to have added considerably to the cost. In the three societies in which the cost was below 2 Kr. there are special reasons to account for this; thus one of the societies was for nurses, who probably are generally given medical service free of cost to them and the insurance society.

The average cost of medical service in the 66 societies was, as stated above, 4 Kr. 13 öre.

Drugs

The average expenditure under this head (exclusive of expenditure on dressings, baths, &c.) was—

4 Kr. or over	in	4 societies.
3 Kr. „ but under 4 Kr.	„	11 „
2 Kr. „ „ 3 Kr.	„	38 „
Under 2 Kr.	„	8 „
		61

Five societies did not pay any benefit of this kind. As stated in chapter XIV., of the 75 societies in Copenhagen and Frederiksberg only 65 paid, as part of benefit, for the full cost of drugs. The others paid only part of the cost or none at all.

The highest expenditure in any society was 6 Kr. 26 öre, in the society for policemen.

Institutional Benefit

The average expenditure of the societies per member on institutional benefit was—

Over 3 Kr. (3s. 4d.)	in	2 societies
2 Kr. and over, but under 3 Kr. ...	„	8 „
1 Kr. 50 öre and over, but under 2 Kr.	„	16 „
1 Kr. and over, but under 1 Kr. 50 öre	„	29 „
Under 1 Kr.	„	11 „
		66

Average for all the societies, 1 Kr. 51 öre (1s. 8d.).

The two highest amounts were 3 Kr. 24 öre and 3 Kr. 09, the former in the blacksmiths' union society, the latter in a sulphuric acid and superphosphate factory society. The two lowest were 30 öre (about 4d.) and 32 öre in a general temperance and a glass-workers' society, respectively.

Cost of Administration

The cost of administration per member in 1910 varied from under 1 Kr. to over 4¾ Kr. It was—

3 Kr. or more	in	6 societies.
2 Kr. „ but under 3 Kr.	„ 27	„
1 Kr. „ „ 2 Kr.	„ 24	„
Under 1 Kr.	„ 9	„
	66	

Among the societies in the last group was the Alderströst, the second largest society in the kingdom, with nearly 16,000 members, an average total expenditure per member of 18 Kr. 26 öre, and a cost of administration of only 93 öre per member. The cost of administration was therefore only about 5 per cent. of the total expenditure. The society is well managed and justly proud of its economical administration.

The Largest Societies

The following are particulars of the average income and expenditure per member of the three largest societies—

A. No. of members.
B. Income from—
   (*a*) Contributions.
   (*b*) State subsidy.
   (*c*) Other sources.
   (*d*) Total.
C. Expenditure on—
   (*a*) Medical service.
   (*b*) Drugs.
   (*c*) Dressings, trusses, baths, &c.
   (*d*) Institutional treatment.
   (*e*) Confinement benefit.
   (*f*) Money benefit.
   (*g*) Administration.
   (*h*) Total.

	A.	B.					
		(a)		(b)		(c)	(d)
		s. d.		s. d.		s. d.	s. d.
(1) Fremtiden	28,515	14	9	5	3	0 1	20 1
(2) Alderströst	15,830	15	11	5	5	0 5	21 9
(3) Fremtids Haab ...	13,314	17	4	5	9	0 5	23 6

	C.							
	(a)	(b)	(c)	(d)	(e)	(f)	(g)	(h)
	s. d.	s. d.	s. d.	s. d.	s. d.	s. d.	s. d.	s. d.
(1)	4 7	2 9	0 2	1 10	0 4	7 6	1 8	18 11
(2)	4 8	3 0	0 1	1 11	0 7	9 1	1 0	20 3
(3)	4 8	3 0	0 4	1 7	0 5	10 6	1 7	22 1

Patients per Doctor

As previously stated, the sickness societies of Copenhagen generally employ district medical officers, the members having no choice of doctor except where "supplementary" doctors have been appointed. The report contains particulars of the number of insured persons falling to the share of each medical practitioner.

195 general practitioners are included in the list.

15 had 2,000 or more insured clients (excluding children).
38 „ 1,000 „ but less than 2,000.
51 „ 500 „ „ „ 1,000.
91 „ less than 500 clients.

The largest number under any one general practitioner was 4,337; the lowest, only 6. Complaint is made at times that some general practitioners have more patients under their care than they can properly attend to.

Most of the doctors act for more than one society; one firm of doctors acted for 37 societies.

As the general practitioner gets 3 Kr. 30 öre (about 3s. 8d.) a year for each insured person (exclusive of 70 öre set aside for specialists) and will, under the present agreement, receive still higher rates later,[1] some of them clearly make good incomes out of their insurance practice. And it has to be borne in mind that the average income of a doctor is probably lower in Denmark than in England.

The above particulars relate only to general practitioners. Insured persons are also allotted to particular specialists

[1] From January, 1912.

to whom they have to go in case of need, just as they are allotted to particular general practitioners. A specialist has of course a much larger number of clients on the average than the general practitioner. One specialist had over 40,000 insured clients. But the proportion of cases needing treatment would be small.

Prescriptions of the Doctors

The report also contains information of the average cost, per insured member allotted to him, of the drugs ordered by each doctor for whom particulars are given at the cost of the societies. Taking only the general practitioners who had more than 500 insured clients—a lower number would afford a quite inadequate basis for any deductions; even 500 is low for the purpose—the average cost per insured person was—

3 Kr. (3s. 4d.) or more ...	...	in the case of 11 doctors
2 Kr. or more, but less than 3 Kr.	„	„ 42 „
Under 2 Kr.	„	„ 19 „

The highest amount was 3 Kr. 57 öre; the lowest, 1 Kr. 34 öre.

The differences are very great. But the figures have to be interpreted with caution. It does not necessarily follow that the doctor is to blame where the amount is high or to be complimented where it is low. But the figures give valuable indications where it may be advisable to direct inquiry, and they afford excellent means of control, especially when the figures are prepared and scrutinized, not only annually, but also at shorter intervals.

APPENDIX XI

COPENHAGEN: MEDICAL ARRANGEMENTS

AGREEMENT MADE BETWEEN THE FEDERATED SICKNESS SOCIETIES, AND THE MEDICAL ASSOCIATION, OF COPENHAGEN: SUMMARY

I

(This is modified by later agreement—see III.)

CONTRACTS OF MEDICAL PRACTITIONERS

1. Medical practitioner appointed by a society (designated medical officer in the following, for brevity) to give medical service to members, and their children under 15 years of age, residing in the district allotted to him.
2. Medical officer to treat sick who attend in his consultation hours, and to attend at home persons not able to attend surgery. Generally not obliged to visit patient on same day as message received unless message received before a time in the forenoon to be fixed between the medical officer and the society.

   To attend cases of dangerous illness or accident as soon as possible, if at home. If so attends and afterwards shown that such attendance not necessary or could have been sought in good time, fine may be imposed on erring member by committee concerned.
3. As regards cases of illness entitling member to money benefit :—Medical attendant to issue notification. Notification to be sent to committee of society by member. Medical attendant also to furnish weekly control notices. If

sick member attended privately, medical officer only to furnish control notices at request of committee of society.

Medical officer to furnish, without additional payment—usual admission order to hospital ; official death certificate ; notification of death to society ; school certificate. Member to pay for all other certificates.

4. Medical officer to examine persons living in his district who seek admission to society, if they present ticket from society's committee. One krone to be paid for each examination by person seeking admission.
5. Medical officer to require evidence that person attended entitled to medical service.
6. Medical officer not bound to vaccinate, to give anæsthetics, to extract teeth, or to perform the more serious operations. Is entitled to direct patient requiring special treatment, which he not able to give, to free public clinic or to specialist appointed by the society.

   Society pays ten kroner (11s. 1d.) for surgical assistance in cases of child-birth or miscarriage.
7. If medical officer advises that hospital treatment necessary and patient refuses to take it, he no longer obliged to attend ; must report matter to society.
8. Complaints against medical officer :—Complaint, written, to be sent to him for explanation (to be given within 14 days) before action taken by committee. No complaint to be made as regards matter which occurred more than three months previously. Complaint not to be brought before General Meeting before being dealt with as indicated above.
9. Medical officer's remuneration—three kroner (3s. 4d.) yearly for every member (man or woman) over 15 years of age resident in his district, except in cases mentioned in sec. 10. No additional remuneration for attendance on children under 15 years of age of members—except in cases where both parents eligible for membership of society, and only one a member: in those cases medical officer paid three kroner yearly for medical attendance on the children, irrespective of the number.

   Remuneration to be paid in respect of each person who has resided in district during last quarter. Paid for each quarter during first month of following quarter.

   Medical officer to be furnished—quarterly, with list of members' identification numbers ; yearly, numbers, names and addresses of members, unless agreement between

medical officer and society to the contrary. List to include, and to distinguish, members for whom State subsidy not paid or who have only dormant rights of membership.

10. Medical officer not obliged to attend members for whom State subsidy not paid or who have only dormant membership.

11. Contract between medical officer and society may be terminated by quarter's notice. If medical officer has been in service of society for at least one and a half years, notice can only be given if grounds stated. In case of dismissal, right of appeal to tribunal constituted according to sec. 13.

    But society has right to appoint additional medical officer for a district, if sufficient reason therefor on complaint dealt with according to sec. 8. If more than one medical officer for a district, members to have freedom of choice. Choice to be made for one year at a time.

12. . . .

13. Against any breach of this agreement, appeal may be made to a tribunal constituted by agreement between the Medical Association of Copenhagen and the joint representative body. No resort to ordinary courts.

II

AGREEMENT IN ACCORDANCE WITH SEC. 13

Disagreements between medical officers and sickness societies, when cannot be satisfactorily settled by parties immediately concerned, shall be brought before a committee consisting of two representatives of the Medical Association of Copenhagen and two representatives of the federated societies.

Every dismissal of a doctor can be brought before this committee for decision.

III

AGREEMENT OF DECEMBER, 1908

1. Fifth member to be added to tribunal constituted under sec. 13 if majority on a question not obtained within a month. This member to act as arbitrator; must be independent of both contracting parties. Chosen for five years.

If contracting parties not agree on arbitrator, Minister of Interior to be asked to appoint : person appointed to be a legal public official, independent of the contracting parties.

2. All future new medical appointments to be notified to Medical Association within at latest three weeks of last day for receiving applications. Vacancies to be published in the journal of Danish Medical Association, free of charge to the society.
3. . . .
4. Normal maximum number of members for a district medical officer to be 2,000. If this exceeded by 500, society may reduce number to normal limit. This to be negotiated between committee of the federated societies and Medical Association.

   If a medical officer now has more than 2,000 members, present number to be maximum. Reduction to this number may be made if it is exceeded by 300.
5. Remuneration—

   from 1 July, 1909—4 kroner per member ;
   „ 1 January, 1912—4 kroner 25 öre per member ;
   „ 1 January, 1915—4 „ 50 „ „ „

   This to include payment for, in addition to ordinary medical service—specialist treatment for diseases of eye and for diseases of ear, nose and throat, and for massage by specialists belonging to the medical association : also, from 1 January, 1912, such examinations by specialists as district medical officers consider necessary and may be made outside a hospital.

   Until 1 January, 1912, societies with not more than three hundred members excused from giving specialist treatment other than that in force at the time of making this agreement. Likewise, societies which are considered to be specially circumstanced, after negotiation between the contracting parties, may be excused specialist treatment, wholly or partly. In so far as specialist treatment not given—twenty-five öre to be deducted from medical remuneration for each of special diseases (eye and ear, nose and throat respectively), and 20 öre for massage.

   Massage treatment may be exceptionally given at patient's home, by agreement between district medical officer and massage medical practitioner.

For eye and ear, nose and throat specialists, provisions as to maximum limit of members similar to those in case of district medical officers (4 above) except that limits are—normal maximum,—14,000; limit of excess—for specialists with 14,000 limit, 2,000; for others, 1,000.

Societies have right to three specialists in each branch, except otherwise agreed with medical association. [Special provision as regards societies with 5,000 or more members.]

6. . . .

7. Agreement not terminable until 1 January, 1915: thereafter, with half-year's notice. But may be terminated within this period, by half year's notice, if radical changes in law relating to sickness societies or in other conditions thereof, including conditions of membership.

A.—*Arbitration award of 25 June, 1908, as to sec. 2, part 3, of Agreement*

Obligation of medical officer to give immediate attendance in cases of sudden dangerous illness or accident:—Medical officer not necessarily required to leave other patient who is being attended by him or other medical obligation incurred: matter must be left to discretion of medical officer. Members may obtain other medical aid if medical officer is prevented from attending in time.

B.—*Arbitration award of December 13, 1905, as to sec. 6, part 2, of Agreement*

Surgical assistance in child-birth or miscarriage:—Includes all necessary medical aid where use of instruments or hands. Injection of morphia or other drug does not count as surgical assistance. Medical officer only receives the 10 kroner for a case, even though surgical assistance has been given on several occasions.

C.—*Arbitration award of March, 1906, as to sec. 6, part 2, of Agreement*

If a member, failing attendance of the medical officer, obtains the services of another doctor, a fee of 10 kroner shall be paid

to the latter in circumstances such as those set out in this section, provided that the necessity of the medical attendance is certified by the medical officer.

D.—*Arbitration award of March,* 1904, *as to sec.* 9, *part* 1, *of Agreement*

The capitation fee is to be paid for each member who was living in the district at the close of the quarter, and for members who, during the quarter, resided in the district and have died or fallen out of membership.

INDEX

Accidents; medical treatment, 6

Administration:
invalidity and old age insurance,
Germany, 6
sickness insurance,
Denmark, 11, 11–2
Germany, 5–6, 32

Arbitration Committees, see *Conciliation and Arbitration Committees*

Benefits:
invalidity and old age insurance,
Germany, 6–7
sickness insurance,
Denmark, 13
Germany, 6

Berlin; institute of Central Committee of Sickness Societies for treatment of members, 176

Burial Benefit, see *Death Benefit*

Capitation payments for medical service:
Denmark, 72–3
fees, combined with payment by, 90–2
Germany, 54...
reasons for, 85–8

Central insurance authority, 98, 99

Certificates:
invalidity, 38–9, 48–50, 71
sickness; inability to work, 108–9, 110–2, 119–20, 120, 257, 264, 269

Children; medical treatment, see *Defendants*

Choice of doctor:
conclusions as to, 43...
Denmark, in, 40–2
different systems, 27–8
free choice:
change of doctor, 41, 262–3, 271
cost of medical benefit, 31, 74, 242–5
employer; attitude towards, 34–5
insured persons; attitude towards, 31–2, 40, 45
Leipsic, 32–3, 236–9, 246–8
medical and surgical requirements, 142
medical profession; attitude towards, 30–1, 40, 43–5
organised free choice, 27, 30–1
should be conceded in sickness insurance, 43–7
societies; attitude towards, 31–2, 40
state; attitude towards, 30
Germany, in, 27...
new law; provisions, 29
invalidity certificates, 48–50

Clinics:
of private doctors, 37, 163, 170, 250, 254–5
of societies, 37, 237, 238, 250

Cologne:
convalescent treatment, 176
doctors, dispute between societies and, 33–4, 112–3, 146, 240–6
institutional benefit, 173–4, 177
medical and surgical requirements; expenditure, 144
medical service; expenditure, 68
pharmacists, disputes between societies and, 136

Communal insurance, 3, 4, 5, 6, 8, 9

Compulsorily insured :
Denmark ; alien seasonal workers, 14
Germany, 1–2

Conciliation and Arbitration Committees, 114–7, 124, 130–1
Copenhagen, 287–8
Frankfort, 273
Leipsic, 258–61
Munich, 269

Conclusions, 212–4

Confidential medical advisers :
invalidity insurance, 38–9, 206
sickness insurance, 69, 70, 86, 109..., 117–8, 123, 127, 129–30, 159–60, 172, 266–7, 269, 270, 273

Confinement benefit, 6, 13–14
see also *Midwifery Cases*

Contractors' societies, 4, 8, 9

Contributions :
invalidity insurance, 3, 4–5, 7
sickness insurance, 4, 11, 278, 279–80

Control of doctors, see *Medical Service*

Convalescent treatment, 109, 162–3, 171–2, 176, 180, 200–1
Leipsic regulations, 265–6

Copenhagen :
hospitals, municipal, 188–9, 190–1
institutional benefit, 181, 183–4, 188–9, 281–2
medical and surgical requirements, 122, 148, 149–50, 150, 151, 281, 284
medical arrangements, 40–1, 41–2, 283–4
agreement between societies and doctors, 285–90
medical remuneration, 72–3, 286, 288
medical service ; cost, 74, 79, 80, 280–1
societies ; details respecting operations of, 279–84

Corporate provision, 215–22

Crefeld ; medical arrangements, 110, 120

Day convalescent resorts, 171

Death benefit, 6, 13–4

Dental treatment, 37–8, 61, 63, 278

Dependants ; medical treatment,
Denmark, 11, 13, 75, 150–1, 286
Germany, 2–3, 6, 60–1, 63, 70, 133, 140, 164–5, 250

Deposit system ; combined with insurance, 92–6, 105, 131, 156–7, 215–6

Dispensing, 133, 148, 157–8

Disputes between :
doctors and societies, 16, 19, 65–6, 73, 228–30, 236–9, 240–6
pharmacists and societies, 136

District medical officers, 28, 34, 40–1

District societies, Germany, 7–8, 9

Doctors, see *Medical Practitioners*

Domestic servants ; insurance against sickness, 1, 9
Hamburg, at, 1, 37, 57, 179–80

Dresden ; medical benefit, 69, 71, 132, 133, 145–6, 164, 180

Drugs, see *Medical and Surgical Requirements*

Düsseldorf ; medical benefit, 110–1, 133, 136–7, 176

Education of insured in matters of health and treatment, 96–101, 160–1, 222–4

Employer :
administration, 5, 6, 11–2
contributions, 2, 3, 4–5, 11
doctor ; choice of, by insured, 34–5
establishment and contractors' societies, 4, 8, 9

Establishment societies, 4, 8, 9

Fees, payment by ;
capitation payments, combined with, 90–2
Denmark, in, 72, 74
Germany, in, 53, 54, 56, 68, 69
reasons for, 88–90

Forest camps, 171

Frankfort, medical arrangements, 33, 55, 270–4

Friendly societies, see *Registered Aid Societies*

Germany : general particulars respecting insurance in, 1...

Guild societies, 4, 8, 9

Halle : dispute between societies and doctors, 245

Hamburg : insurance of domestic servants, 1, 37, 57, 179–80

Hospitals :
abuse, hospital, 89–90, 172, 185, 197–8, 242–3
capital costs, 165–6, 168–9
charges : Denmark, 12, 181, 182–3, 184
Germany, 165–6, 168–9
confidential medical advisers : examination of cases, 109
control over sending cases to, 122, 172, 264
Denmark, in, 73–4, 182...
Germany, in, 165...
Leipsic society regulations, 263–4
maintenance costs, 166–7, 184
staff, 169, 229
voluntary, 170, 185, 217
see also *Institutional Benefit* and *Convalescent Treatment*

Housing loans by invalidity insurance authorities, Germany, 209

Income limit, 101–6
Denmark, 10, 77–9
Germany, 1, 2, 65–7, 272, 275–6

Institutional Benefit :
assistance towards, 165–7, 181–2, 193–7

Institutional Benefit, *continued*—
conclusions as to, 192...
conditions as to receipt of, 163, 172–3, 197–8, 201–3
Denmark, 181...
dependants, for, 11, 164–5
expenditure on, 173–6, 177, 178–80, 186–9
general medical practitioners, 170–1, 185, 195, 198–9
Germany, 162...
money benefit in addition to, 162, 164–5, 186, 278
necessity for, 192–3
nursing at home, 199–200
organised doctors, administration by, 216–8
societies, provision of institutions by, 171, 176, 186, 197, 217, 218
see also *Convalescent Treatment* and *Hospitals*

Insured persons :
Denmark, 10–1
Germany, 1–2, 232, 233, 235

Invalidity and old age insurance, Germany :
administration, 4, 6
benefits, 6–7, 266
certificates, 38–9, 48–50, 71
finance, 4
insured, 1–2, 2

Kiel ; institutional benefit, 165, 179

Königsberg ; medical benefit, 70, 118, 146–7

Landkasse, 6, 9

Leipsic :
analysis of sickness records, 98–9
confidential medical advisers, 109, 266
convalescent treatment, 170, 176
dispute with doctors, 236–9
institutional benefit, 164, 178
medical and surgical requirements, 132, 133, 144, 145
medical arrangements, 32–3, 54–5, 108–9
agreement with doctors, 246–67

Leipsic, *continued*—
medical service ;
expenditure on, 68, 69
particulars of, 70
remuneration of medical practitioners, 54–5, 68, 248–9, 250, 254–5

Leipziger Verband, 227–30, 231

Local authorities ; assistance towards insurance, 5, 12

Malingering, 17, 109, 112, 123, 171
hospitals ; use of, for detecting, 173
Leipsic regulations, 252, 265

Medical and surgical requirements :
charges, 133, 134, 135–6, 148, 149–50
conclusions as to, 154...
control, 108, 109, 110, 122, 138–9, 150, 159–60, 257, 269, 273, 276, 284
Denmark, 148...
education as to use of, 160–1
expenditure on, 140–7, 150–2
Germany, 132...
Leipsic ; instructions to doctors, 252
part-cost, payment of, 148–9, 152–3, 156–7
patent medicines, 143, 149
provision of, 154–6
societies, supply of, direct by, 136–7, 158–9
what provided, 132–3, 140–1, 148

Medical benefit, administration of, 15–6, 19–26

Medical organisation :
Denmark, 41, 124
Germany, 35, 227–30, 231

Medical practitioners :
contract with society (Leipsic), 251–5
democratisation of medical profession, 83–5
disputes with societies, 16, 19, 65–6, 73, 228–30, 236–9, 240–6
legislative protection, 30, 228, 229
numbers, 231–5
organisation, 35, 41, 124, 227–30, 231

Medical practitioners, *continued*—
patients ; number of, 42, 57–8, 231–5, 283–4, 288, 289
residence ; qualifying period, 35
working classes, recruiting from, 83–5
see also *Choice of Doctor, Medical Service, Remuneration, Specialists,* and *Unqualified Practitioners*

Medical referee, 113, 123, 267

Medical Service :
Control of,
conclusions as to, 125...
Denmark, 121...
deposit system, 92–6, 131, 156–7, 215–6
doctors' organisation, through, 22–3, 108–9, 110–3, 119–20, 126–30, 220, 253–4, 255..., 269, 272–3
free choice, 47, 107–8, 123
Germany, 107...
medical and surgical requirements ; payment of part cost, 149, 156–7
medical referee, 113, 123, 267
need of, 125–6, 129–30
records, 113–4, 118–9, 122, 276, 283–4
cost of,
Denmark, 73–80
Germany, 58–65, 67–70
dependants, see under *Dependants*
doctors' organisation, provision through, 90–2, 216–20
kind, obligation to provide in, 15–9, 28, 29–30, 66–7, 72
money in lieu of, 16, 29–30, 66–7, 72
services rendered ; particulars (Leipsic), 70
supervisory authorities ; intervention, 15, 28–9, 237, 240–1, 245,
see also *Medical Practitioners*

Medicines, see under *Medical and Surgical Requirements*

Midwifery cases, medical service in, 13–4, 56, 68, 272, 286, 289–90

Mileage money, 56, 68, 253

Miners' societies, 8, 9

Money benefit, 6, 13
with institutional benefit, 162, 164–5, 186, 278

Munich:
institutional benefit, 164, 176, 178
medical and surgical requirements; expenditure, 145
medical arrangements, 33, 55, 109, 119–20, 268–70
medical service; expenditure, 69–70

Nature treatment, 36, 143
see also *Unqualified Practitioners*

Nursing, home, 199–200

Old age insurance, Germany, see *Invalidity and Old Age Insurance*

Old age pensions, Denmark, 10

Patent medicines, 143, 149

Period of benefit, 6, 14, 62, 63–4, 76

Pharmacist:
control, 133–4, 139
corporate provision, 218–9
Denmark, 148
free choice, 135, 149
Germany, 133...
societies, disputes with, 136–7

Prescriptions, see *Medical and Surgical Requirements*

Prevention of disease, 7, 18, 21, 86–7, 162, 208–9, 222–4

Public health authorities and insurance, 204–10

Public relief:
hospitals, in, 167, 188
privileges to insured (Denmark), 12

Records of sickness, 97–9, 113–4, 118–9, 122, 276, 283–4

Registered aid societies, 3, 8, 9
State registered aid societies, 9

Reichsverband, 35, 230

Remuneration of medical practitioners:
conclusions as to, 81...
corporate responsibility, 216–20
Denmark, 72...
deposit system, 92–6
form of, 51–7, 68, 69, 72–3, 74, 85–92, 220–1
Frankfort, 272
Germany, 53...
institutional treatment, 170–1, 172, 195, 198–9
Munich, 268, 269
number of doctors, 18, 81
part payment from insurance funds, 92–6, 105, 131, 215–6, 250, 254–5
rates of, 62–5, 68, 72–3, 81–5, 224–5, 248, 250, 254–5, 268, 272, 275–6, 286, 288
salaries, 56–7
Stuttgart, 275–6
tariffs, medical, 53, 72
see also *Capitation payments* and *Fees*

Seasonal workers, alien (Denmark); compulsory insurance, 14

Sickness, persons insured against:
Denmark, 10–1
Germany, 1–2, 232, 233

Social democrats, 32, 65, 87, 183

Societies, insurance:
administration, 5–6, 11, 32
Copenhagen, in; details respecting, 279–84
finance, 4, 11
German societies, details respecting twenty-eight, 277–8
insured person belongs, to what society, 3, 11
kinds, 3, 7–9, 11
membership, 3–4, 9, 11

Specialists, 53, 62–3, 73, 76, 254–5, 283–4, 288, 289

State medical service, 23–6, 76

Strikes and boycotts, medical, 16, 19, 66, 228–9, 236–9, 240–6

Stuttgart, medical arrangements, 275–6

Subsidy:
Denmark, 12, 75, 80, 181–4, 189, 280
Germany, 2, 5, 167

Supervision:
Denmark, 11, 207
Germany, 5, 15, 28–9, 207, 237, 240–1, 245
Public health authorities, 206–7

Survivor benefit, Germany, 7

Tariffs, medical, 53, 72

Transport (Denmark), free 12, 181

Tuberculosis, treatment of,
Denmark, 181–2, 189, 190, 204–5
Germany, 7, 176, 205

Unified medical service, 23–6

Unqualified practitioners, 35–6, 50–2

Urgent cases, attendance on, 28, 252, 283, 289

Valetudinarianism, 17, 92–4, 96–7, 160–1, 224

Visitors, for sickness control, 100, 119, 123

Voluntary insurance,
Denmark, 10
Germany, 2, 3, 66–7, 110

Widow and orphan benefit, Germany, 7

Wives, medical benefit to, see *Dependants*

Women, insurance of, 2–3, 11, 75
See also *Dependants*

LONDON: P. S. KING AND SON, ORCHARD HOUSE, WESTMINSTER.

80756

UC SOUTHERN REGIONAL LIBRARY FACILITY
A 000 708 109 4